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ABSTRACT

One of six publications of the Research Advisory Committee of the National Association for Retarded Citizens, the monograph presents guidelines for using behavioral procedures with retarded individuals in residential settings, group living homes, sheltered workshops, or other settings. Addressed are the following topics (sample subtopics in parentheses): historical antecedents of behavioral approaches (recent legal decisions): behavioral procedures (personnel qualifications, procedures for strengthening behavior, specific prescriptive procedures for the humane management of behavior problems: contingent education procedures: guidelines for the use of more severe treatment procedures such as time out and contingent electric shock: and procedures for advice, review, and consent (committees for external review of procedures and certain treatment decisions). Among six appendixes are suggested procedures for contingent observation and overcorrection, and recommended program monitoring procedures for use by the committees on legal and ethical protection. (CL)

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GUIDELINES FOR THE USE OF BEHAVIORAL PROCEDURES IN STATE PROGRAMS FOR RETARDED PERSONS

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GUIDELINES FOR THE USE OF BEHAVIORAL PROCEDURES IN STATE PROGRAMS FOR RETARDED PERSONS

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GUIDELINES FOR THE USE OF BEHAVIORAL PROCEDURES IN STATE PROGRAMS FOR RETARDED PERSONS*

This report is the product of a joint Task Force assembled by the Florida Division of Retardation and the Department of Psychology of the Florida State University on June 17, 1974. The goal of this Task Force was to provide the State of Florida, and other states that may wish to adopt it, a document outlining philosophy, procedures and safeguards recommended for use in the State's administration of behavioral programs. This Task Force included some of the nation's leaders in the application of behavior principles to handicapped clients, some of the foremost legal authorities engaged in the protection of the legal and civil rights of the handicapped, and some of the leaders of national organizations dedicated to enhancing the welfare of the retarded. Members of this Task Force were:

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After the Task Force concluded its meeting, a preliminary document was compiled from the individual reports and discussions that occurred. This was circulated to all Task Force members, and feedback incorporated into the final version by the Co-chairmen and the Editor. The preliminary document was also forwarded to the Director of the Florida Division of Retardation who identified points requiring clarification for use by the State of Florida.

Although this document reflects the input and concensus of all Task Force participants, this is not meant to imply that all participants would have written it in the same way.

ABBREVIATIONS

Below is a complete list of all abbreviations used in the text of this document:

AABT = Association for Advancement of Behavior Therapy
AAMD = American Association on Mental Deficiency
APA = American Psychological Association
CLEP = Committee on Legal and Ethical Protection
FARC = Florida Association for Retarded Children
HRAC = Human Rights Advocacy Committee
HRS = Department of Health and Rehabilitative Services
NARC = National Association for Retarded Citizens
PRC = Peer Review Committee

FOREWORD

These guidelines focus on the use of behavioral procedures in programs for retarded individuals in residential settings, group living homes, sheltered workshops, or any setting where services are delivered to retarded clients. The guidelines emphasize the clients' behavioral needs and means of meeting them, so that they may develop to their fullest potential and enjoy a satisfying life. Although in many instances the fulfillment of these goals requires residential living, the ultimate goal is to help return the client to his natural community with whatever support is necessary.

A succinct statement of the theoretical and attitudinal framework in which this Task Force operated in its commission is as follows:

1. A view of behavior has emerged from psychological research, based on learning and behavioral principles, that recognizes and emphasizes the potency of the enviornment in determining human behavior. This view implies that behavior can be acquired, modified, or eliminated through programming that enhances the conditions under which such changes can optimally take place.
2. Based on this view, certain behavioral procedures which have been commonly used for generations have in this century been refined more effectively to enhance the conditions for change and thereby aid in human development.
3. The absence of any procedures will also have an impact on behavior since a client's environment acts upon him all the time, often resulting in the bizarre forms of behavior and stunted growth found in barren environments. Destructive environments, as well as those which foster growth, must be identified.
4. This Task Force is concerned with developing guidelines to deal with two issues:
   a. the identification of optimal developmental goals, and
   b. the identification of the types of environments and behavioral procedures which will help realize these goals.
5. Whenever any procedure is used to alter behavior, it is recommended that the following safeguards exist:
   a. the involvement of the consumer in decision-making,
   b. the implementation of procedures only by qualified, competent people, and

c. the assurance that ethical and legal issues be reviewed by informed citizen committees.

6. With regard to retarded persons, this Task Force adheres to four basic principles:

   a. **Normalization**: retarded persons should live like normal persons to the greatest degree possible;
   b. **Developmental model**: the use of procedures to optimize a normal sequence of development;
   c. **Individualization**: the recognition and fostering of uniqueness in every person within broad limits of social acceptability; and
   d. **Self-enhancement**: enhancing opportunities for each client to make his own decisions and shape his own life.

   Adherence to these four basic principles requires that the least drastic alternative procedure available must be used in achieving developmental goals.

I. HISTORICAL INTRODUCTION

Historical Antecedents of Behavioral Approaches

In recent years attitudes toward the nature and treatment of "behavior disorders and deficiencies" have been changing sharply. The traditional view of the non-changeability of institutionalized persons such as the "mentally ill" and "retarded" resulted in hopelessness and frustration on the part of staff as well as "patients." This explanatory model conceived of all unusual behavior as evidence of a "disease" process or organic deficiency and any assistance to the individual was simply custodial care until a "cure" was discovered.

However, in the 1960's there emerged an alternative view of behavior emphasizing the importance of the individual's current physical and social environment. The "mentally ill" or "retarded" person was seen as a human being with "needs" and "rights" who was amenable to the influences of his environment in a manner not basically different from that of any other human being. Most importantly, he could also participate in the planning of his own environment. Investigators working within this conceptual framework developed specific procedures which institutional staff could use to have some impact on the development of the clients in their care.

Many different professional groups, including psychologists, psychiatrists, social workers, nurses, and teachers, contributed to the development of behavioral philosophy and procedures. These professionals held a common set of principles concerning systematic observation of behavior in relation to the current environment, careful planning of this environment, careful evaluation of the effectiveness of procedures, and the role of every staff member in facilitating the development of clients. More than a simple change in procedures, these principles represented a developing philosophy of behavior which focused on training of staff to rethink their goals, to be optimistic of change, and to realize that their own behavior was an important part of the clients' environment.

The professional people working in this area referred to the new approach by a variety of names, including "behavior modification," "behavior therapy," "contingency management," and "applied behavior analysis." Generally, all of these terms referred to a model of social learning and the importance of the responses of other human beings. The use of physical and chemical procedures

such as psychotropic drugs, electroconvulsive therapy, and psychosurgery were clearly and unequivocally disavowed as behavioral procedures by these investigators.

It must be emphasized that behavioral philosophy and procedures should never be simple or mechanical. Not only do they involve the arrangement of the physical and social environment, but their context is the needs of the total human being in his total environment, allowing for self-determination to the fullest possible extent.

Historical Antecedents of Institutions and Programs for the Retarded

The recent appearance of modern behavioral programs in institutions for the retarded and concerns about the abuse of such programs are part of a much longer history of such service and concern. In the past 150 years there has emerged a variety of definitions of retardation as well as a wide range of service programs in residential and community settings.

When Samuel Gridley Howe became director of the first state institution in Massachusetts in 1848, program goals for his small group of "idiots" focused on retraining for community life. Education was based on the work of Sequin and Itard in France, which foreshadowed the current, more systematic application of behavioral principles. Howe's early reports of successes were so impressive that similar institutional programs were established in most states, sometimes without the careful attention to the quality of treatment originally present.

Residential facilities grew into large institutions during the early twentieth century, and the ratio of success to failure diminished. "Idiots" became "the mentally deficient," and goals were increasingly oriented toward the protection of these individuals who were considered "incurable." Concurrent concerns about genetic etiology led to the notion of incurability, as well as to sterilization laws and gross overcrowding of institutions. Education, treatment, and training were secondary considerations.

In the 1930's cultural and social factors in intellectual development were recognized. For example, studies done at the University of Iowa questioned the "immutability of the IQ," and professionals in the field of mental retardation gradually changed their orientation. Adaptation to the environment and current intellectual functioning were emphasized. Mental retardation was redefined to refer to subaverage intellectual functioning with con-

current deficits in adaptive behavior, and the degree to which an individual was retarded was seen as a function of his environmental history, his biological makeup, and the interaction of these factors. Thus mental retardation was no longer viewed as a fixed entity within the individual. With this change, the outlook for both the retarded individual and the professional became more optimistic and the notion of the optimal development of each individual became a realistic goal.

With the development in the 1960's of behavioral procedures for strengthening adaptive behavior and weakening maladaptive behavior, it became clear that these were relevant and applicable to retarded persons for whom psychotherapy and traditional education approaches had been relatively ineffective. However, just as the early institutional programs expanded rapidly, leading to breakdowns in effectiveness as well as abuses, behavioral programs have expanded so rapidly that occasions of abuses and mis-uses by well-intentioned but ill-informed individuals and occasionally deliberate mis-uses with malicious and sadistic intent have resulted. It is essential that safeguards be established for the appropriate use of behavioral procedures since such procedures can clearly contribute to the development and enjoyment of life of the retarded individual.

Historical Antecedents of Legal Safeguards

Present confusion on the part of both the deliverers and the consumers of retardation services concerning the proper safeguards for and limitations on behavioral and other programs derives not only from the abandonment of the "disease model" and the concept of the "asylum," but also from the rapidly changing social-legal context. The past three years have seen a revolutionary change in the conception of the role of retarded persons and in society's willingness to build this new role into the legal system.

Retarded citizens and their families previously operated under an "alms" model of services. Treatment, education, and employment were favors granted by legislators or administrators; the retarded had no recourse if such favors were denied. In the past few years, however, lawyers representing retarded or otherwise mentally handicapped persons have made a systematic effort to articulate and implement the statutory and constitutional rights of this historically neglected minority through test-case litigation. This effort is analogous to the campaign successfully conducted on

behalf of the other neglected or under-represented minorities as part of the civil rights movements of the 1960's. As a result of such landmark legal decisions as **Wyatt v. Stickney** and **Welsh v. Likens** (right to treatment), **Pennsylvania Association for Retarded Children v. Board of Education** and **Mills v. Board of Education** (right to education), and **Souder v. Brennan** (right to fair compensation for productive labor), the mentally handicapped have recently been cast in the role of "consumers" or "clients" rather than as "alms seekers." Administrators of institutions are no longer perceived as having any special power to grant or deny favors, but rather as just another group of administrators of human service programs whose powers are clearly delimited and who are accountable for their decisions. Whereas traditionally society forgot completely about a retarded individual after he entered a residential institution (attending only to issues of admission and release), scrutiny has now extended to all facets of the delivery of services. Thus recent public concerns about the abuse of behavioral programs, whose purpose is to strengthen adaptive behavior and weaken maladaptive behavior by providing a favorable physical and social environment, must be seen in the context of a general increase in attention to various types of "treatment" which are potentially abusive.

In **Kaimowitz v. State Department of Mental Health**, for example, a three-judge state court in Michigan ordered an absolute ban on psychosurgery for involuntarily committed mental patients. The court noted that psychosurgery is presently irreversible, intrusive, highly experimental, and dangerous and that at its present stage of development, the risks of psychosurgery in institutions clearly outweigh the benefits. Since in the inherently coercive setting of an institution residents could not give a truly voluntary consent to such radical proceedings, the court held that any psychosurgery in Michigan would illegally infringe upon a resident's First Amendment right to mental integrity and Fourteenth Amendment right to be free from cruel and unusual punishment.

In a subsequent development of the **Wyatt** case in Alabama, potential coercion – in this instance, coercion causing mentally retarded residents at Partlow State School to consent to sterilization – was again of concern to the court. The court recognized the danger that sterilization might be recommended not for the benefit of the residents but for the convenience of the administrators of the institution. However, because sterilization might be validly sought by a resident as a birth control alternative, the court refrained from issuing a blanket ban, as was done in the psycho-

surgery case. Instead, the court imposed rigorous procedural safeguards designed to insure that the decision of a Partlow resident to elect sterilization would be competent, informed, and voluntary. In a related case, **Relf v. Weinberger**, a Washington, D.C., federal court enjoined HEW guidelines for sterilization at federally funded health clinics because they inadequately protected minors from being coerced into undergoing sterilization on the threat that their families would be deprived of welfare benefits.

Recent Iowa, California, and Alabama cases (**Knecht v. Gillman, Mackey v. Procunier**, and **Wyatt v. Stickney**) have focused on "treatment" programs utilizing noxious stimuli (succinylcholine and electric shock). The courts hearing these cases have expressed concern that such programs might violate the constitutional rights of the participants and have outlined some appropriate safeguards.

Legislatures in California, Massachusetts, New York, North Carolina, Washington, Idaho, Ohio, Oregon, and Wisconsin have responded to these same constitutional concerns by passing or proposing statutes which would regulate intrusive treatments, primarily by requiring consent.*

While this Task Force abhors abuse of clients under any "treatment" modality, our purview is confined to abuse within behavioral programs for the retarded. Behavioral programs, like any others, are subject to abuses which might also illegally infringe upon the constitutional rights of the mentally handicapped; the litigation and legislation described immediately above suggest the nature of the scrutiny to which such programs may be subjected.

Behavioral programs seem destined to receive special attention at this time because they have been inappropriately linked by the popular press with other treatments such as psychosurgery; because the behavioral approach requires an explicit and objective statement of goals (sometimes unspecified in other therapies); and because it claims to be more effective than other therapies in promoting or weakening certain behaviors. All of the concerns expressed about other "treatments" are also implicit in the use of behavioral programs. One must ask whether the goals or the means of such programs are consistent with the Constitution; whether the client is receiving fair and complete information about the

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* See, e.g., Cal. Welf. & Inst'ns Code SS 5325 (f)-(g) (West Supp. 1974); Ga. Code Ann. S 88-502.3(a) (1971); Mass. Gen. Laws Ann. ch. 123, S 23 (Supp. 1972); N.Y. Mental Hygiene Law S 15.03(b) (4) (McKinney Supp. 1973); N.C. Gen. Stat. S 122-55.6 (1974); Wash. Rev. Code Ann. S. 71.05.370(7) (Supp. 1974); ch. 193, S 24, [1973] Idaho Laws 379; ch. 838, S 28 [1973] Ore. Laws 2831; Ohio No. 984, 110th Gen. Assem. (1973); S.C.S. 539, 1973 Gen. Assemb. S 9. See also, Wis. No. 484, 1973 Assem., S 15 (pendency terminated at end of legislative session).

procedure, the risks, and the benefits; and when, if ever, the rights of others or of society justify the use of programs for a non-consenting "client."

Since the appropriate use of behavioral procedures can effectively and greatly contribute to the personal growth and development of retarded persons, it is crucial that such concerns translate into guidelines for use, rather than simply prohibition. Such guidelines must specify not only procedures which are effective but also the safeguards necessary to protect the human and legal rights of clients. Formulation of standards for the proper use of behavioral programs is also necessary so that conscientious persons can administer them with a sense of security. Although one of the outcomes of the proper utilization of behavioral approaches is an avoidance of instances of client abuse, this is by no means the primary purpose of these guidelines, which is to ensure that the best possible services are available to retarded clients.

II. BEHAVIORAL PROCEDURES

Just as other human beings, retarded individuals have potentials for growth, learning, and development, and the fulfillment of these potentials is greatly influenced by the total environment. These guidelines focus on the use of behavioral procedures in programs for retarded individuals in any setting where they are served. These procedures are designed to meet the clients' behavioral needs so that they may develop to their fullest potential and enjoy a satisfying life. Specific objectives are: (1) to increase competence to cope with the environment, (2) to foster increasingly more complex adaptive behavior, and (3) to enhance human qualities. Programs must capitalize on each individual's existing competencies by selecting behavioral goals to build on current skills and to help the individual progress along the normal developmental sequence.

It is strongly emphasized that this Task Force is not recommending as a "program" the usual segmented therapy approach practiced in most residential facilities for retarded persons. In most such facilities the living environment, the ward or unit, provides custodial care in a usually barren setting, devoid of materials, activities, and social interaction. Clients who have the prerequisite skills are sent away from this environment for short periods of time to such activities as "speech therapy" or "music therapy." Large numbers of clients, however, do not even have the opportunities. Behaviors taught during such therapy sessions are not typically supported and maintained since the client cannot practice them on the living unit, and they have no utility on the living unit. For example, even if a client is taught in speech therapy to point or vocalize when he wants a toy or other object, he has little opportunity to use this skill on the ward since there are few, if any, movable objects and little ongoing interaction between staff and clients. Or, if he has learned in recreational therapy to ride a bicycle, he will be unable to maintain this skill in a ward without bicycles, an outdoor play period, or a staff member who will respond favorably to his performance. In this type of "program" it is more likely that the client will return from therapy sessions to the ward and engage in disruptive behavior or do nothing. Too many opportunities to "do nothing" will probably result in the loss of any skills the client may have acquired, thus further removing him from opportunities to leave the ward.

In planning programs caution should be exercised to avoid the use of brief or ineffectual treatment merely in token satisfaction of an individual's right to treatment. A short therapy session which is presented to others as a "program" will probably be far

less effective than a living unit designed to maintain appropriate behavior, even though the latter is not usually thought of as a program.

Therefore, any specific procedures for strengthening or weakening behavior which are discussed in this section can be maximally effective in contributing to the client's development only in the context of a stimulating environment; the effects of the specific procedures are inseparable from the total physical and social environment in which the client spends most of his time. The first step in any program, then, is to ensure that clients have the continuing opportunity to participate in their environment, to become engaged in activities, and to talk to staff and other clients. Thus living units and other places where clients spend their time must have available materials and structured activities, and staff members must be trained to engage continuously in social interactions with residents. Such an environment would not only prevent the loss (due to non-use) of skills clients have but would contribute heavily to the practice and elaboration of any skills a client might learn in specific therapy sessions. Ideally, any skills a client learns in educational programs away from the living unit would be further supported and elaborated when he returns to the living unit, and new skills should be acquired in the context of daily activities on the living unit.

Clients who have numerous opportunities to engage in adaptive behavior are unlikely to develop a great deal of disruptive behavior. However, such behavior will occasionally occur in any living environment, and specific procedures must exist for dealing with it. Such behavior may range from mild disruptions such as throwing a toy to severe aggressive or self-destructive behavior which not only interferes with programs but infringes on the rights of other clients to be free from physical harm. It must be emphasized that when dealing with such behavior the focus is always on strengthening alternative forms of desirable behavior rather than on simply weakening the undesirable behavior.

The following sections discuss the organizational context of programs and procedures for strengthening and weakening behavior. Although a number of terms have been used in behavioral approaches to describe the process of adding behaviors to an individual's repertoire (i.e., accelerating, developing, increasing), we have chosen to refer to this process as the strengthening of behavior since this term implies duration, quality, and intensity as well as frequency. Similarly, we have chosen the term weakening, with its connotation of a decrease in intensity, duration, and

quality as well as frequency, to apply to the process of decreasing behaviors in an individual's repertoire.

Organizational Context of Behavioral Programs

The purpose of behavioral programs is to develop and maintain skills in the areas of self-help, language, social behavior, emotional and personality adjustment, academic behavior, and vocational skills, and to develop environments where these skills are functional and frequently used. Goals for each client are based upon his demonstrated competence, motivation, and environmental circumstances, ideally allowing him to participate in the decision-making process to his fullest capability.

Behavior Programs and Procedures

Behavioral programs and procedures, as any other programs, will only be successful if they are implemented in the context of an efficient organizational structure which includes assessment, planning, implementation under supervision, monitoring, feedback, and program revision and extension.

Individual assessment. In planning a behavioral program, a client's repertoire should be assessed by criterion-referenced tests, which measure the dimensions of sensorimotor, self-help, language, academic, pre-vocational, vocational, and community readiness skills. It is strongly recommended such assessment procedures be developed and elaborated to give the details needed for prescriptive behavioral programming in each category.

Program planning. Behavior increases in complexity and adaptability through a developmental sequence from the psychological reflexes of the infant to the competent and varied performance of the adult. For practical purposes, this sequence can be divided into the areas of sensorimotor development, mobility, self-help, language, social, emotional and personality development, academic skills, and vocational skills. Across the entire range of development, behavior objectives can be specified so that the content to be used in client evaluation instruments and the content and procedures to be used in strengthening or weakening behavior can be determined and the client can begin to behave as successfully as possible at his developmental level. In specifying program content, each form of behavior being taught should be related to subsequent and more complex forms of behavior specified by the developmental sequence.

Qualifications of Personnel

The Task Force recognizes that many abuses and mis-uses of behavioral procedures occur because of the lack of competent staff to design and implement programs. However, it is also recognized that many facilities do not have available to them people of the level of competence that this committee would like to recommend, and that requiring this level of competence might delay or prevent the implementation of some of the procedures outlined in the guidelines. Therefore, as a compromise, the Task Force recommends the following qualifications for the present, while recognizing the need for more highly qualified staff.

Our staff qualifications are divided into two categories: formal educational criteria and experience, and behavioral criteria. The latter refers to the requirement that staff display competence in carrying out procedures or supervising others in order to retain their positions or be promoted. There are a variety of ways to train staff in such skills, and we are therefore indicating the terminal criteria rather than specifying the content and procedures of training.

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RESIDENT LIFE ASSISTANT (RLA)

Formal Qualifications: High school graduate or equivalent experience.

Behavioral Criteria: Until meeting the following criteria, a person holding this position is on probationary status. The Supervisor should evaluate performance according to a pre-specified set of written criteria. The employee must demonstrate the basic skills of differential reinforcement and extinction in the context of maintaining a minimum level of interaction of one contact per minute with clients. Error rate in differential reinforcement and extinction should be no higher than 10%. The Resident Life Assistant should also be able to implement under supervision some of the training procedures appropriate for the population.

RESIDENT TRAINER (Trainer - Instructor)

Formal Qualifications: High school graduate or equivalent experience.

Behavioral Criteria: Promotion to this position is based upon successful completion of the requirements of RLA, and demonstrated skill in all of the training procedures appropriate to that population and in keeping records on client progress. Evaluation on a pre-specified set of written criteria should be done by the Director of Residential Training Programs.

UNIT MANAGER OR DIRECTOR

Formal Qualifications: Two years of college or equivalent experience.

Behavioral Criteria: This person must have demonstrated competence in the duties of RLA and Resident Trainer, and in addition have successfully supervised RLA's in implementing training procedures. Evaluation on a pre-specified set of written criteria should be done by the Director of Residential Training Programs.

SUPERVISOR

Formal Qualifications: Four years of college and experience.

Behavioral Criteria: The Supervisor must have experience in successfully supervising others in implementing all of the training procedures and health care routines relevant to the population. An extremely important requirement is that the individual be able to give formal feedback on staff performance, particularly inadequate performance, and be able to write the necessary reports on client progress in training programs.

ALL UNITS: DIRECTOR OF RESIDENTIAL TRAINING PROGRAMS

Formal Qualifications: Master's level specialist.

Behavioral Criteria: This person must have formal training including practicum experience in all behavioral procedures relevant to the population, the ability to locate information and training packages, the ability to organize and implement them, and supervisory skills. He/she should have no additional administrative responsibilities.

DIRECTOR OF PROGRAMS AND SERVICES or OUTSIDE CONSULTANT

Formal Qualifications: Ph.D. or equivalent.

Behavioral Criteria: In addition to the skills of the Director of Residential Training Programs this person must have a broad knowledge of all other programs operating in the institution, i.e., education, music therapy and recreation therapy, and the ability to integrate them into a coordinated, full-day program.

Use of Consultation

Almost any program within an institution will be incomplete and thus consultation between a client's treatment teams and a hierarchy of behavioral experts is almost essential. The hierarchy of expertise for consultation includes the supervisor of an institution, the director of residential training programs. director of programs and services, coordinator of behavioral programming for the state, and local outside consultants.

It is recommended that states add the position of Coordinator of Behavioral Programming to the staff of the Division of Retardation. This person should report directly to the division director and be responsible for authorizing the use of behavioral procedures and working with regional directors to carry them out. The State Coordinator would act as a central source of information and coordination, and the regional directors would be held accountable for carrying out his or her directives. The Coordinator should have had wide training and background in behavioral approaches, be continuously responsive to new developments in the field, and be in contact with persons of national stature in both research and administrative positions.

Procedures for Strengthening Behavior

Many programs for strengthening various adaptive behaviors are available. One of the prime repsonsibilities of the State Coordinator should be to obtain a comprehensive list of such programs and choose those most relevant to the various institutions for implementation.

Strengthening behavior is primarily accomplished by providing positive consequences or reinforcers after a desirable behavior occurs (positive reinforcement). Initially, every occurrence of the behavior is reinforced; later reinforcement follows only some occurrences. When a reinforcer is given too frequently, however, the recipient may become tired of it (satiated) and it will no

longer function as a reinforcer. It is therefore necessary to assess continuously the efficacy of the substances or events used as reinforcers. The choice of reinforcers to be used in a program can only be made by knowing the needs and likes of clients. Every effort should be made to discover what types of events function as reinforcers for particular clients. Sometimes snatches of song or the sight of objects can prove so strong that more basic, appetitive reinforcers will not be necessary. Some positive consequences which may serve as reinforcers are described here.

Intrinsic reinforcement. Intrinsic reinforcement, or natural reinforcement, is undoubtedly the most important in the normalization process. It refers to acts which produce their own rewards (for example, turning a doorknob opens the door; flipping the light switch illuminates the room). The more relationships of this type that can be built into an environment the easier it becomes to shape and maintain appropriate behavior. In the non-institutional environmental, intrinsic reinforcement abounds. One does not normally need token reinforcement to encourage persons to swim, ski, or learn to drive a car. Sports, games, hobbies, and most forms of social interaction are maintained by intrinsic reinforcement, as is solving a jigsaw puzzle or climbing a mountain. Intrinsic reinforcement should be the most pervasive and frequent consequence in behavioral programs.

However, some forms of behavior are not initially intrinsically reinforcing. For example, riding a bicycle or reading a book require prerequisite training, the motivation for which may require other forms of reinforcement.

Social reinforcement. The most pervasive event functioning as a reinforcer in almost any setting is the response of another person. Praise, physical contact, smiles, and conversation can be used in many contexts to strengthen behavior. This is a preferred form of reinforcement, particularly for social behavior such as cooperative play or language. There are some clients for whom social responses do not function as reinforcers. Since this severely limits a client's ability to develop in any way, special procedures for making social responses reinforcers by pairing with other reinforcers may be used.

This Task Force takes the position that positive social interaction between institutional staff and clients is a primary and critical prerequisite to any effective program of habilitation or training.

Artificial reinforcement. The term "token economy" specifies artificial or contrived arrangements in institutional settings where

the client receives tokens for working, studying, shaving, talking, or, in the more general sense, for engaging in appropriate or adaptive behavior. Subsequently, the client can exchange tokens for sweets, cigarettes, outings, or any other item or event which functions as a reinforcer for him. Token reinforcers avoid the problems inherent in the use of food as a reinforcer because they can be used to obtain many items and so have value even when the client isn't hungry, are convenient for both clients and staff, and can facilitate transition to the exchange system of society.

In the view of this Task Force, a token economy should be used as a means to a defined behavioral objective and should not become the objective itself. For example, if a token economy is used to strengthen behavior, the system should be gradually eliminated as social reinforcement and various forms of intrinsic reinforcement become effective consequences. For adolescents and adults, the token economy should be shifted gradually to the normal economy of the "outside world." For example, one does not normally get paid for shaving, dressing properly, eating with a fork, talking, or playing ping pong. Pay is given for work, and work for the client should be defined as the same form of activity as work for other people. Pay should approximate the amount received for a particular activity by a person outside of the institution. Such progression from a contrived token economy to the one functioning on the outside of the institution is thus part of the "normalization process."

Appetitive reinforcement. The use of food or liquids as reinforcers is necessary when a client is not amenable to the intrinsic or social reinforcers in his environment. Although some foods, such as sweets, are often powerful reinforcers regardless of the time of the client's last meal, a period of deprivation can contribute to the reinforcing effectiveness of food and may be necessary to make it effective for a client.

Since food deprivation involves an ethical and legal consideration concerning depriving a client of basic rights, certain safeguards must be established for its use. Therefore, no deprivation should occur which results in the intake of less than the normal amount of food. When less drastic alternative procedures have been ineffectual, such deprivation may be deemed necessary for a particular client and should then be approved by the advisory groups on a case-by-case basis and be contracted for by the state Division of Retardation.

Another option for increasing the reinforcing effectiveness of food lies in the use of mini-meals, in which the total daily diet is divided into five or more smaller meals. This permits the use of

each mini-meal as a reinforcer for a particular training period, while not reducing the total amount of food available to the client. Such a procedure should receive prior case-by-case review by the advisory groups.

It must be emphasized that food deprivation or dividing the daily diet into mini-meals is never to be used as a means of weakening behavior, but rather in the context of increasing the motivation of a client to participate in a training program.

Procedures for Weakening Inappropriate Behavior

Normal development involves not only the acquisition of new behavior but also the elimination of ineffective, inappropriate, or maladaptive behavior. Usually, when new behaviors develop old ones are weakened, but in some cases maladaptive behaviors persist and impede the establishment of new behaviors. It thus appears that some behaviors must be weakened before others can be efficiently established.

In many cases the presence of a maladaptive behavior, its abnormally high frequency, duration, or amplitude, or its occurrence at inappropriate times or places marks an individual for special treatment. Many such maladaptive behaviors are of special concern not only because they interfere with the activities of other members of society or are incompatible with the acquisition of appropriate behaviors, but also because such behaviors often result in the individual's being physically excluded from society and from conditions conducive to further behavioral development.

The following set of guidelines specifies procedures which can help promote the more normal development of retarded individuals by weakening maladaptive behavior. These procedures include those which have a low potential for abuse, but rather are so essential for development that their absence should be considered an infringement of the rights of retarded clients, and which must be an integral part of each client's living environment; procedures which are socially acceptable and have a low potential for abuse and can therefore be generally used by direct care staff; and procedures which are potentially very abusive of the individual and can only be recommended for use under a strict set of guidelines specifying the circumstances of use and supervision by advisory groups.

Avoidance of Inappropriate Behavior

The basic way to weaken problem behaviors is to eliminate the reasons for their occurrence. In any setting, with any group of people, problem behaviors occur primarily when people are not involved in goal-directed activities, when they must idly wait, and when materials, activities, or people which engage their interest are not readily available to them. Thus problem behaviors can be avoided by providing materials, activities, and social interaction appropriate to the interest level and skills of each client.

Thus, when inappropriate behaviors occur, the environment in which the client spends his time and exhibits the problem behaviors must be examined. The setting should be surveyed at regular intervals throughout the day for several days and a count made of the clients in that setting who are actively engaged in watching or interacting with materials, activities, or people at that moment in time and whether the client in question is so engaged. It should also be noted which staff members are giving attention to the clients or to other activities, such as housekeeping. Such "spot checks" if done frequently and regularly (e.g., every half hour) throughout the day for several days will provide a workable diagnosis of the environment in which the problem behaviors are occurring and suggest the remedial procedures which must be employed before more direct measures are taken. If most of the clients are found to be not engaged for some parts of the day, more engaging materials and activities must be planned and provided for those times. If most clients are engaged throughout the day but the client in question is not, special materials and activities more appropriate to his interest and skill level should be sought, or he should be transferred to another environment where appropriate materials and activities are available. If staff members are not giving their time to the clients but are busy with housekeeping chores, more staff should be provided and/or more efficient housekeeping routines instituted. If staff members are giving their time to neither clients nor housekeeping, training and supervision procedures should be reevaluated and strengthened.

Once a client is appropriately engaged in activities throughout the day and staff members are devoting a substantial portion of their time to the clients, most behavior problems which occur can be handled and severe behavior problems can be prevented by skillful staff members trained in the procedures of differential reinforcement and extinction.

Extinction of Inappropriate Behavior While Concurrently Reinforcing Appropriate Behavior

Most problem behaviors, even the most bizarre and severe, occur because they produce results for the client. Retarded clients often engage in self-stimulatory, destructive, disruptive, aggressive, or self-injurious behavior because they produce immediate and predictable responses from other clients and staff members. Indeed, in a barren environment with an inattentive (or insufficient) staff, such problem behaviors may be the only means clients have of obtaining physical and social stimulation. Such a custodial environment is in violation of a retarded client's right to an adequate living environment which will support his development.

To avoid this infringement of basic human rights, institutional staff must be trained to provide materials, organize activities, and prompt and facilitate appropriate and more skillful behaviors while the client is engaged. The staff must be trained to provide frequent attention, praise, and assistance for all appropriate forms of interaction with materials and other people, and to ignore inappropriate behaviors so as not to inadvertently strengthen them (Williams, 1959; Wolf, Birnbrauer, Williams and Lawler, 1965).

Thus when the client is provided with a general supportive and engaging environment and the staff are actively giving their attention to clients but a particular client's problem behavior still occurs, the staff's level of skill in differential reinforcement must be examined. Each staff member should be observed briefly (e.g., for five minutes) periodically throughout the day on a rotating basis for several days. A count should be made of the number of times the staff member contacts any client and the number of times he/she contacts the client in question. Each contact should be evaluated according to whether the contact was contingent upon appropriate or inappropriate behaviors of the client. A low frequency of contacts, a significant proportion of inappropriate contacts, or a disproportionately low number of appropriate contacts with the client in question would suggest that additional staff training and supervision were needed in order to reduce the level of problem behaviors.

Whenever human interaction occurs, some behaviors are reinforced while others are ignored. In their dealings with clients, therefore, direct care staff are delivering consequences for behavior. For staff members to be more effective in dealing with inappropriate behavior, they must learn to be more precise and skillful in consequating behavior.

Thus staff members must be taught to completely ignore any instances of inappropriate behavior and to heavily reinforce each instance of incompatible appropriate behavior. The provision of a high level of interaction among staff members and clients, where these procedures are skillfully used, will be especially effective in preventing the occurrence of such maladaptive behaviors as aggression or self-stimulation. Such interaction is essential for the development of complex behaviors such as language, which requires many instances of interaction. Staff members must understand their daily ongoing responsibility for building such complex behaviors, rather than assuming that they will be developed in short training sessions. Furthermore, staff must be alerted to the fact that responding to primitive forms of a behavior when the client is capable of more complex forms only delays development.

The extinction of inappropriate behavior and concurrent reinforcement of appropriate behavior is difficult to use after a client has developed a high rate of maladaptive behavior. If such is the case, staff members should be aware that when a client is ignored for a particular behavior, he will temporarily engage in more of that behavior. It is important that staff members continue to ignore the behavior completely and to prompt more appropriate behavior, since attending to the inappropriate behavior will further strengthen it. However, it is highly likely that staff members will inadvertently reinforce instances of the behavior; in addition, if the behavior is being supported by the social group rather than by staff members, it may mean that the peer group must be taught how to interact more appropriately with the client. This aspect is particularly important with higher functioning, more verbal individuals.

These disadvantages make extinction and concurrent reinforcement much more suitable as preventive rather than remedial measures. These procedures would not usually be the only ones recommended if an individual's behavior caused harm to himself or others or greatly disrupted his environment.

The successful implementation of extinction and concurrent reinforcement requires continuing in-service training so that direct care staff become increasingly aware of the effects of their behavior on clients. Also, since no one person is completely responsible for all of a client's living experiences, each staff member must be aware of and coordinate his own interactions with those of the other staff.*

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*A variant of extinction and reinforcement of incompatible behavior is called a differential reinforcement of (unspecified) other behavior, or DRO.

Specific Prescriptive Procedures for the Humane Management of Behavior Problems

Extinction and concurrent reinforcement* must form the essential ingredients of staff-client interactions throughout the day and will be particularly effective in the prevention of behavior problems. However, since problems that interfere with individual development and group functioning will occur, just as in any living environment, there must be specific procedures to deal with them. These will not only help provide an environment where individuals can attain maximum physical, social, and intellectual development, but also ensure that staff members do not improvise disciplinary procedures which may be ineffective, arbitrary, or abusive.

A number of procedures have been impirically demonstrated to weaken a wide range of behavior problems in numerous populations and settings. These procedures involve the programming of events contingent upon behavior, in order to reduce the future probability of that behavior and provide an opportunity for appropriate behavior to occur (Bijou and Baer, 1961; Azrin and Holz, 1966; Bandura, 1969; Baer and Sherman, 1970; Risley and Baer, 1973; MacMillan, Forness, and Trumbull, 1973). These procedures include timeout (Wolf, Risley, and Mees, 1964; Bostow and Bailey, 1969; Barton, Guess, Garcia, and Baer, 1970), response cost or effort (Sailor, Guess, Rutherford, and Baer, 1968; Barrish, Saunders, and Wolf, 1969; Jacobson, Bushell, and Risley, 1969; Phillips, Phillips, Fixsen, and Wolf, 1971; O'Brien, Azrin, and Bugle, 1972), overcorrection (Foxx and Azrin, 1972; Webster and Azrin, 1973; Foxx and Azrin, 1973); and the application of

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*With this procedure, reinforcement is given whenever the inappropriate target behavior is <u>not</u> occurring, regardless of what other behavior is emitted, even doing nothing. The problem behavior is completely ignored. Initially reinforcement is provided almost continuously whenever the problem behavior is not occurring, but the length of time between reinforcements is increased as rapidly as possible. This produces short periods of time when the inappropriate behavior is not occurring, and the client can be shifted to an educational program of reinforcement of specific incompatible behaviors. For example, a client who screamed most of the time would be initially reinforced whenever he wasn't screaming. Then, specific incompatible behaviors, for example, requesting something appropriately from an attendant, could be targeted.

Although this procedure should also be an integral part of staff-client interaction, continuous in-service training is required because of the high level of skill and supervision necessary to successfully implement this procedure.

painful stimuli, i.e., electric shock (Risley, 1968; Lovaas and Simmons, 1969; Corte, Wolf, and Locke, 1971). All of these procedures are based upon general principles of behavior.

However, each of these techniques must be assessed not only in terms of its effectiveness in helping an individual, but also in terms of public acceptability, the moral issues and social repercussions associated with its use, and its potential for abuse. Regardless of the effectiveness of a procedure when properly applied, it will not be used if the public believes that it is a cruel, inhumane, or unusual method of discipline, or if it can easily be abused by those directly responsible for its application.

Thus, when procedures for dealing with behavior problems are recommended for general use in public settings such as institutions for the retarded, more than their effectiveness is at issue. They must be described in terms of common experiences and common practice (ideally). They must be described in familiar terms that can be readily understood. Supervisory and direct care staff must be able to understand and describe what they do and to indicate the benefits to clients, so they can convey these messages to the public in a way which will avoid misunderstanding.

Furthermore, procedures recommended for general, daily use by direct care staff must not be easily susceptible to social abuse. Any of these procedures can be used inappropriately or used to weaken behaviors that are adaptive and acceptable for a client. For example, a certain amount of assertive behavior on the part of a client would not be considered aggression and is probably essential to his development and ability to function in his social group. Thus it becomes important to specify what types of behaviors these procedures should be used to weaken.

Effectiveness, acceptability, and susceptibility to social abuse are not necessarily correlated. Timeout in a bare, locked closet and electric shock, for example, are effective when properly applied but are rarely publicly acceptable. People cannot relate these procedures to their own experience or to familiar methods of child-rearing, and may confuse them with child abuse. Therefore, timeout behind locked doors and the use of electric shock cannot be recommended for general use since they are potentially hazardous to the client's welfare and publicly unacceptable. The use and supervision of these procedures for certain dangerous behaviors will be described later. Following are descriptions of three contingent education procedures which can be delegated to direct care staff for general use, under supervision, for the management of behavior problems.

Contingent Education Procedures

These contingent education procedures — contingent observation, educational fines, and overcorrection—have been deliberately developed to weaken inappropriate behavior by teaching alternate forms of acceptable behavior. They are prescribed to occur contingent upon the inappropriate behavior. Moreover, they have been deliberately described to be understood and accepted by the general public, and, because their potential for abuse is minimal, they can be administered by direct care staff. They can also be recommended for use by parents and guardians. Furthermore, these three procedures emphasize the teaching of appropriate behavior and thus make a positive contribution to a program for the retarded. The rationale upon which contingent education is based not only reflects learning principles but is familiar to most parents and teachers: that the best time and place to instruct a client in appropriate behavior is when and where he behaves inappropriately. The three forms of contingent education involve the interruption of the activities of a client who is behaving inappropriately and the use of that occasion to teach appropriate behavior.

Contingent observation. Contingent observation combines elements of exclusion time-out (Wolf, Risley, and Mees, 1964) and modeling (Bandura, 1969), and assumes a program of well planned activities for the clients. A client who is doing something inappropriate is asked to step away from the activity for a few moments, sit in a chair nearby, and watch the appropriate behavior of other clients. The staff member deliberately attends to other clients who are appropriately behaving in ways the client should observe. The client rejoins the activity after a few moments of observation and after indicating that he intends to behave appropriately. After returning to the activity, he receives feedback from the staff member for appropriate behavior. Clients who leave the chair or refuse to sit and watch, either because the ongoing activities distract them or because they are upset, are taken to another area where they can practice sitting or calm down before they return to the chair to watch the others. A step-by-step description of the contingent observation procedure, as it would be written for inclusion in a staff training program, appears as Appendix A.

Educational fines. Educational fines are used in the context of a token economy or point system. To weaken inappropriate behaviors with educational fines, the fines should be small so they can be used frequently for minor as well as major instances of the behavior, and a portion of each fine should immediately be returned to the client for a display of appropriate incompatible behaviors.

Furthermore, each fine must be accompanied by a teaching episode which includes a description of the inappropriate behavior, the amount of the fine, instruction on the appropriate form of the behavior, and the opportunity for the client immediately to "earn back" a portion of the fine for practicing the appropriate behavior. If the client displays the appropriate incompatible behavior, he is praised, a portion of the fine is returned to him, and the episode ends. If the client refuses to practice the appropriate behavior, the episode ends without a return of a portion of the fine. If the client exhibits argumentative, abusive, or other inappropriate behavior when fined, he may receive an additional educational fine. However, the client should receive an immediate opportunity to display appropriate behavior and thereby re-earn a portion of the second fine (and then the first fine), then the episode should be terminated regardless of the client's behavior. A step-by-step description of the educational fine procedure, as it appears in the Achievement Place Staff Training Manual, appears as Appendix B.

Overcorrection. Overcorrection, a technique developed by Azrin and his colleagues, is based on the principles of response cost (cf. Weiner, 1962), prompting (Konorski and Miller, 1937), and motor learning (Woodworth and Schlosberg, 1954), and programs on active educational episode after the occurrence of inappropriate behavior. Overcorrection is most appropriate in situations where there is no program of planned activities from which clients can be removed to watch, or when contingent observation does not prove effective. The client is taught to assume responsibility for the disruption to the environment caused by his inappropriate behavior by restoring the environment to better than its original condition (restitution) and by intensively practicing the appropriate behavior (positive practice). The client is given instructions concerning the actions he must perform, and if he cannot follow them, he is manually guided by the staff. The overcorrection procedure has been used to reduce self-stimulatory behavior as well as aggressive and disruptive behavior. A step-by-step description of the overcorrection procedure, as it would be written for inclusion in a staff training program, appears as Appendix C.

Appropriate Uses of Contingent Education

Although contingent observation, educational fines, and overcorrection are based upon similar principles, the context of other aspects of the environment determines the procedure of choice. Contingent observation will be most effective and is recommended for situations where a program of planned activities exists. Clients can observe appropriate behavior only when opportunities are

provided for others to engage in appropriate behavior. Moreover, if a client enjoys an activity, removing him from it for a short time will motivate him to behave appropriately in the future. He is also more likely to sit in the chair near the activity, since having to go to another area to practice sitting or to calm down will delay his return to the activity. In settings where enjoyable activities do not usually occur, clients would probably have to be removed from the activity area more frequently.

Where a token or point system is well established, educational fines would be primarily relied upon to reduce problem behaviors (although contingent observation might still be used during some group activities). Educational fines will be more effective when the client is frequently able to buy a variety of items with his tokens. The fewer the opportunities to buy and the more restricted the selection of items and privileges available, the less effective educational fines will be in reducing inappropriate behavior – and the more often inappropriate behavior will occur during fining episodes. If a client is regularly purchasing a variety of items and privileges with his tokens, educational fines will be effective in reducing inappropriate behavior, and he will be eager to earn back a portion of the fine by practicing appropriate behavior.

In situations where contingent observation has not been effective (usually because the programmed activities are not reinforcing to a client), and where a token system is not being used or educational fines are not effective (usually because the client is not consistently earning and spending tokens), then overcorrection can be used. The client's behavior is not only interrupted by overcorrection, but he must expend a great deal of effort in restitution and positive practice. The avoidance of the effort provides the incentive to behave more appropriately in the future. If staff are engaged in carrying on a structured activity program, they will not have time to use overcorrection but will probably not need to use it as often as when few activities occur.

Potential Misuses of Contingent Education

Each of these contingent education procedures can be escalated to the level of mild abuse and under some circumstances even substantial abuse. Under contingent observation the client can be left in the observation chair long after he is prepared to participate properly or left in another area long after he is calm or is sitting quietly. Educational fines can be excessive, and requirements for appropriate behavior to earn back a portion of the fine can be made impossibly high. In overcorrection manual guidance can be given so forcefully as to be painful. The verbal explanation

and instruction accompanying each procedure can be the occasion for demeaning or insulting remarks.

These potentials for mis-use and mild abuse require that explicit limits and regular monitoring be specified for each procedure and that staff members be thoroughly trained in their use. However, with specific limits, monitoring, and training, these contingent education procedures can be prescribed for problem behaviors of individual clients or for general use with categories of problem behaviors of all clients in a setting and implemented by most members of a supervised staff.

When contingent observation is used in a setting where the ongoing activity is engaging and reinforcing for a client, the observation period need only be long enough to offset the possible reinforcing effect of the educational instructions – a few seconds' removal from a highly engaging activity (e.g., eating), a minute's removal from an adult-structured, well-organized activity, several minutes' removal from a passively supervised play time with other clients and toys, up to 15 minutes' removal from a situation with opportunities only for client-initiated interactions with staff, other clients, or materials. In all cases the observation period should continue until the client is quietly watching the ongoing activities and can indicate an agreement to behave appropriately. Beyond this duration, increasing the length of the observation period is unlikely to increase the effectiveness of the procedure. Accordingly, a note should be made in the client's record whenever he sits in the observation chair longer than say, 15 minutes before he indicates he is ready to again participate appropriately. Similarly, a note should be made whenever a client must be sent to another area to practice sitting or to calm down, and the time he is sent and returns should be recorded. If the client must be sent to another area, that area must be within visual and hearing range of a staff member at all times. If the door between that area and the ongoing activity area must be shut or latched, that fact should be noted and a staff member must be stationed at the door so as to easily see and hear the client at all times. Any five such notes (e.g., longer than 15 minutes in the chair, being sent to another area, and door having to be shut between areas) in any week would require that the team responsible for the client's program review his program to determine if adequately engaging activities are being provided for him or if another procedure is needed to correct his problem behavior. Only those staff members who have been trained and who have demonstrated their competence in implementing contingent observation (including making the appropriate statements accompanying each step) with several

clients should be allowed to use the procedures routinely. Contingent observation should only be used for those clients and those behaviors explicitly prescribed by the treatment team.

The educational fine procedure should likewise explicitly be prescribed by the treatment team for each client and each behavior problem. In no case should a fine be greater than approximately 10% of a client's average daily earning (and he should have the opportunity to earn back half or more of each fine immediately for practicing appropriate behavior). In addition to the normal token records, an explicit note should be made whenever a client does not earn back a portion of a fine, or whenever he loses half or more of his daily token earnings in fines. Any five such notes in any week should require a review of the client's program by the treatment team to determine if there are adequate opportunities to earn tokens and an adequate variety of things to purchase for the client, or if another procedure is needed to handle his problem behaviors. Only those staff members who have been trained and who have demonstrated their competence in implementing educational fines (including making the appropriate statements accompanying each step in the procedure) should be allowed to use the procedure routinely.

Where the overcorrection procedure is used, the amount and type of restitution and positive practice must be explicitly prescribed by the treatment team for each client and each behavior. Since overcorrection would normally be prescribed when contingent observation or educational fines are not effective or not available, it is likely that the client is not engaged in ongoing activities or not participating in the token economy. Therefore, it is particularly important that each overcorrection episode by sufficiently prolonged and effortful to override the potential reinforcing effect of the social interaction involved in the overcorrection procedure. Thus in contrast to the other two contingent education procedures, each overcorrection episode should not be brief. Twenty to thirty minutes of continuous restitution and positive practice is the recommended length of each episode (with the exception of self-stimulatory behaviors where five minutes is the recommended length). Since overcorrection requires somewhat more skill and persistence than the other contingent education procedures, it is to be expected that fewer of the staff members will be trained and competent to implement it. In addition to a regular record of each overcorrection episode, a special note should be made whenever a client actively resists manual guidance during the procedure. Five such notes in any week should require a review of the client's program by the

treatment team to determine if overcorrection may be reinforcing in contrast to an inadequately engaging environment, and whether another procedure might be needed to deal with the client's problem behavior.

In order to prevent abuse, any procedure for weakening behavior can only be implemented when there is evidence that a client actually has behaved inappropriately. Usually, this requires that a staff member actually witness the inappropriate behavior. In special circumstances, i.e., a client self-government system, the reports of other clients can suffice. If a particular client is consistently reported as behaving inappropriately only by one particular staff member, then an inquiry should be instigated. It may be that the staff member is either prompting the behavior or enforcing more rigid standards than other staff members.

Reasons for Failure of Contingent Education Procedures

The failure of contingent education procedures of contingent observation, educational fines, and overcorrection to weaken inappropriate behavior may indicate that more severe treatment techniques are required for a particular client. However, before such a decision is made it is necessary to examine the context within which these educational techniques have been employed, and the consistency with which they have been employed.

One cause of the failure of contingent educational procedures is an environment devoid of possibilities for appropriate behavior and activities which are reinforcing for the clients. Effectively to weaken behavior by removing an individual from a situation requires that the situation be reinforcing for him and that other clients be actively engaging in appropriate behaviors for him to observe. Employing an educational fine requires that the individual be able to purchase reinforcing items every day. In a more barren environment, therefore, contingent education procedures will have to be employed more frequently and to less effect than in an environment where programs and activities are provided. If such is the case, a reorganization of the environment, rather than the use of more severe techniques, is necessary.

Another cause of the failure of contingent education techniques is their incomplete or inconsistent use by staff members. All of these procedures diminish greatly in effectiveness if they are not used after every instance of the inappropriate behavior, and if components of the procedures are only partially used or omitted. If the procedures are ineffective because of inconsistent or incomplete use, then staff training and supervision are necessary, rather than resorting to more severe techniques.

Although the extended periods of practice recommended for the use of overcorrection will usually assure that the episode is not reinforcing for most clients, there are some clients for whom it will either be a reinforcer or be ineffective in weakening an undesirable behavior. These will probably be clients who have many attention-getting behaviors and for whom any type of staff attention-getting behaviors and for whom any type of staff attention is a reinforcer. In such cases, improvement of staff training and supervision is necessary to provide increased attention for appropriate behavior.

Exclusion timeout and fines. For some clients, particularly those whose behavior during implementation of the procedures causes disruptions and those whose inappropriate behavior does not diminish even though the procedure is being used consistently, it may be necessary to temporarily discontinue the educational components of the procedures while continuing the contingent response to the maladaptive behavior. Contingent observation without the educational components is called exclusion timeout and involves simply removing a client from an activity to another area in the living environment for a short period of time, without talking to the client or requiring him to watch or respond appropriately. Educational fines without a description of the inappropriate behavior or the opportunity to earn back a portion of the fine for responding appropriately are simply called fines. The educational components of these procedures should be discontinued only as a prescription for particular clients and only after review by the behavioral programming team. In addition, the change in procedures should be reported to the Committee on Legal and Ethical Protection (CLEP, see page 36). As in the contingent education procedures, records of use must be kept.

Guidelines for the Use of More Severe Treatment Procedures

Contingent observation, educational fines, and overcorrection are contingent education procedures that have been explicitly developed and described for use by institutional staff for the management of behavior problems. However, procedures must also exist for those clients whose behavior problems are not amenable to these educational techniques. Some clients may be so dangerous to themselves or others that they frequently or continuously require heavy sedation, physical restraints, or seclusion in a locked room as emergency procedures and seclusion timeout or electric shock as treatment procedures until they become responsive to less drastic methods.

In some circumstances certain procedures (non-behavioral restraints) must be instituted on an emergency basis for the physical protection of the client himself, other clients, and staff. Physical restraints such as jackets, cuffs, splints, or specially constructed seclusion rooms must at times be used to handle crises. In most cases these are not considered behavioral (learning) procedures but are used until an educational program can be developed and implemented. These procedures can only be implemented in the presence of a professional person and should never be considered a substitute for a learning program.

The plight of these clients who are not amenable to educational procedures necessitates the use of more severe treatment techniques for the reduction of behavior which is dangerous to themselves. These techniques include seclusion timeout and the use of aversive stimuli such as loud noises, strong social reprimands, and electric shock. These techniques should not be in general use by direct care staff. Although effective when properly applied, they are not publicly acceptable for general use and are potentially more abusive than contingent education procedures. When such procedures are considered necessary they should only be used following careful review on a case-by-case basis by the Peer Review Committee (PRC, see page 35) and the Committee on Legal and Ethical Protection (CLEP). This review should be particularly concerned with the qualifications of the treatment personnel who propose to implement the procedures. If evidence cannot be provided that the treatment personnel have been explicitly and formally trained to conduct the proposed procedure, the treatment should be provided on a contractual basis by adequately trained professionals. The following procedural rationale and description are presented to provide the information necessary to monitor and evaluate such treatment.

Seclusion timeout. Seclusion timeout in a locked room may be necessary for severe aggressive behavior when contingent education procedures are ineffective or cannot be used. Such a situation exists when a client is so physically strong and behaviorally resistive that trying to apply contingent education procedures would endanger the physical well being of both that client and other clients and staff; or when a client displays such severe and skillful aggression that the behavior must be eliminated before even more severe damage occurs. (Seclusion timeout should be distinguished from exclusion timeout which simply involves removing the client to another area of his environment.)

Under these conditions, the client's program committee might prescribe the use of seclusion timeout in a specially constructed locked room for a special behavior problem. This prescription should be immediately implemented on an interim basis under the following guidelines:

(a) The seclusion timeout room used must not permit the client to injure himself. The room should be free of objects or fixtures that can be broken or used to inflict injury.

(b) A staff member must be explicitly assigned to the area of the timeout room for continuous monitoring of the client. The room must have a window or opening permitting visual monitoring of all portions of the room.

(c) The client should be confined to the room only until he is calm and otherwise indicates responsiveness to social interaction. If this time extends to one hour, one of the senior persons on his prescriptive program committee must be immediately called and be in continuous attendance until the end of the episode.

(d) Records should be made of the time the client entered the room and the time he left it. Notes should be made of the circumstances surrounding the episode and the client's behavior before, during, and after each timeout episode.

When a prescription for seclusion timeout is written, the client's program must be immediately and thoroughly examined. The procedures described above for evaluating the adequacy of his living environment in engaging his interest and in providing differential social reinforcement for his behavior should be implemented. Transfer to another living environment where the staff and residents are less endangered by his problem behavior should be considered.

This client's program, with this additional information, should be immediately reviewed by a Peer Review Committee and by the regional Committee on Legal and Ethical Protection. As long as seclusion timeout is continued in use for particular behaviors, the client's case should be re-reviewed every 30 days.

Contingent electric shock. The use of contingent electric shock is prescribed only if a client displays behavior which poses an acute danger to his own physical life or that of others. Implicit in the decision to use contingent electric shock is the guiding principle that if the aversive procedures have to be used, then they entail a small amount of pain and discomfort relative to the large amount of pain and discomfort which the client will experience if the behavior is left untreated. This is the main guiding principle in all

use of aversive procedures with clients and is analogous to similar principles used in medicine and dentistry.

For the use of electric shock to be prescribed, a client must exhibit self-destructive behavior of such severe form as to pose a direct threat to his life, as in breaking his skull or cutting his arteries, or an indirect threat through infections which may be brought about by the tissue damage that he inflicts. Examples of the kinds of self-mutilatory behavior which might call for the use of electric shock are the client's banging his head against a wall or sharp pieces of furniture to the point of bleeding and swelling of tissue, biting various parts of the body such as fingers and shoulders so that large pieces of flesh and bone are removed, chewing off fingers, pulling out fingernails with teeth, gouging eyes with fingers, or violently hitting his knee against his face so as to break his nose. Some clients may damage their genitals or rectums by scratching or manipulation. In addition to posing an immediate danger to the client's survival, these behaviors obviously curtail a client's social, emotional, and intellectual development.

Certain other forms of behavior might in some cases also be handled by the use of aversive procedures. Foremost among these behaviors is eating objects that may endanger the client, for example, a client may swallow nails or pieces of plastic and glass, requiring periodic surgery for removal. Aversive procedures might also be prescribed for clients who engage in such severe self-stimulation that educational procedures are ineffective or those who pose severe problems for other clients and staff members by severely attacking them and endangering their lives, and in general brutalizing their social environment.

If a client is observed to have certain behaviors that endanger his life or seriously interfere with his future psychological development, then the client should be observed to make certain that in all probability the behavior will not "spontaneously" disappear in the foreseeable future. In other words, no aversive procedure should be used unless the behavior has been in existence for several months and shows no consistent signs of decreasing, which would indicate that an intervention was not necessary. Such a baseline may be obtained simply by counting the number of times the client engages in dangerous behavior during particular time periods during the day and the amount of time that the client is placed in restraints.

Once the baseline is obtained, it is necessary to determine that interventions other than aversive procedures have been tried in the past. If they have not been tried, they need to be explored. These

interventions may include differential reinforcement of other behavior, moving the client to another ward (e.g., less crowded conditions with more adult stimulation), and attempting to teach him more acceptable forms of communication.

If it is concluded that the problem behavior in all probability will not "spontaneously" disappear and that various procedures for attenuating this behavior have failed, the type of intervention to use with this particular client must be determined. Ideally, it is preferable to begin with the mildest treatment, extinction, in which staff members simply turn away and ignore the client when he hurts himself. This technique is based on two considerations: (1) individuals engage in self-destructive behavior primarily to gain the attention of others; thus, data show that if both social attention and concern are given contingent on self-destructive behavior, then that form of social attention and concern serves to increase or strengthen that behavior; (2) data also show that if attention and concern are removed contingent upon self-destructive behavior, then the severity of the behavior tends to be decreased or weakened. The main disadvantage of extinction is that it takes a long time to work. That is, if a client is placed on extinction for self-destructive behavior it may take days or weeks before his rate of self-destruction decreases, and typically during the early phases of extinction there is an initial increase in the self-destructive behavior. There are some clients who are so self-destructive that they probably would injure themselves seriously during this kind of treatment. This is particularly true of clients who bite themselves on the wrists (near blood supplies) or hit themselves in particularly vulnerable parts of the body, as the eyes. The second drawback of the use of extinction in institutions is that the staff finds it highly aversive to do nothing while a client is severely damaging himself. That is, staff members have usually been instructed to pay attention to and show concern for a client when he is self-destructive, and therefore extinction procedures run counter to what they have been taught. This, combined with the demoralizing effects on staff of seeing the client hurt himself makes it very likely that the client will experience inconsistencies in treatment; that is, sometimes he will recieve attention and sometimes extinction. Such inconsistencies make a problem behavior particularly durable and resistant to change.

If aversive procedures are to be used, it is usual to start with a mild procedure such as saying a definite "no" while giving the client a mild slap before moving on to more serious or severe interventions, such as the use of electric shock. It has been reported informally that some clients, and they may be a minority, are so

sensitive to disapproval that merely a loud "no" and a mild slap is sufficient to terminate the behavior. More often, such clients may be so "hardened" or "toughened" by the time they come to treatment that only a very drastic intervention such as electric shock will suffice. One should also be aware that for some clients a loud "no" and a mild slap actually serves to strengthen the behavior. Testing a variety of aversive procedures should be avoided since the client adapts to aversive stimulation, which renders it useless. (In general, the effectiveness of aversive procedures should be established within the first minute or two and certainly within the first half hour of treatment.)

If electric shock is to be used the client should be left free to hit himself; therefore, restraints should be removed. As soon as he hits himself the attending therapist applies the shock; for example, the shock stick (Lovaas and Simmons, 1969; Corte and Wolf, 1971) is placed on the client's leg for one second and at the same time the therapist says a loud "no." Typically, this procedure will cause the client to delay his next self-mutilating response from 5 to 30 seconds. As soon as his self-destructive behavior resumes, the therapist reapplies the shock in the same manner as before. The second (or third, fourth . . . tenth) shock should cause increasing delays in responding. It is of course paramount that the behavior be shocked as soon as it occurs, usually within 2 or 3 seconds. By the time the client has been given five to ten shocks in this manner, the problem behavior should essentially be terminated.

The termination of the behavior will be situation specific. Although the client is taught to suppress his behavior in the presence of one therapist, it does not necessarily follow that the behavior will not recur in other situations. For example, if a client has been shocked in his bedroom and is removed from his bedroom to the living room, his self-destructive behavior may resume in the new environment. Similarly, if the client has been shocked by Therapist A, and Therapist B now enters the room and A leaves, the client may again resume self-destruction. In general, these instances of self-destruction require the application of less aversive stimulation than the first time the behavior was suppressed. For example, Therapist A may have had to shock the client ten times in order to gain suppression, while Therapist B may only have to shock the client three or four times. Similarly, after the client has been punished in a sufficient number of environments and by a sufficient number of people, the behavior will stay suppressed in all environments. But it is important to note that there is situation specificity associated with the use of punishment, and this can only be overcome if the client is punished by more than one person in more than one environment. It appears as if the

client soon learns what he can get away with in each environment. This finding is characteristic of clients who are retarded, psychotic, or both.

Punishment has traditionally been avoided because of suspected undesirable side-effects. Experimental data on severely disturbed children, however, have shown these side-effects to be therapeutically advantageous; that is, the client is reported to seem more alert to his environment, to seek the company and affection of therapists, to stop whining and fussing, and to be more affectionate (cf. Forehand and Baumeister, in press, for a recent comprehensive discussion of studies relating to this statement). However, this may not be true of all clients, so that potential undesirable side-effects should be carefully monitored. For example, electric shock should not be applied to a client who is self-destructive if the side-effect of that shock is an intense fear of the environment.

It is difficult to establish the intensity level of aversive stimulation required for a particular client. Use of a few quite painful shocks, instead of several less painful ones, is recommended, primarily to avoid possible adaptation. Since some clients have actually torn off their limbs in order to control their social environment, there is a real danger that a client may quickly adapt to the relatively minor discomfort associated with shock. In general, if there is no substantial reduction in the level of self-destructive behavior within the first half-hour (within the first 10 shocks), the procedure should be discontinued. Any effects of electric shock on behavior will be very rapid and easy to detect.

Just as it is necessary to obtain a baseline of the self-destructive behavior prior to treatment, it is essential that an objective record of the client's behavior be maintained during and after electric shock treatment to help determine whether the aversive procedures should be continued or not.

In addition to correct application of these aversive procedures, it is absolutely critical that as soon as the client is suppressing his self-destructive behavior, some alternate and acceptable form of behavior must be strengthened. Since self-destructive behavior has served the client by controlling his social environment it is essential that he be taught a more adaptive and constructive form of interaction. If such constructive and positive modes of interaction are not established, then the suppression of the self-destructive behavior will be only temporary, and will be replaced by another form of behavior which is equally undesirable. Hence, as soon as the client withholds his self-destruction, the therapist immediately offers him affection and attention, often coupled with food or

other appetitive reinforcers, contingent on not engaging in dangerous behavior, and verbal reassurances such as "That's a good fellow who sits so nicely and looks at me." This is analogous to the differential reinforcement of other behavior (DRO) procedures discussed earlier in this section. In a very gradual fashion the client is first reinforced for merely attempting an eye-to-face contact with the therapist. Under a very gradual and step-like fashion this therapist then introduces the kind of intellectual program, such as language building, that will allow the client to acquire a better form of communication with his social environment. Experience has demonstrated that it is pointless to attempt a suppression of the self-destructive behavior without simultaneously attempting to build more appropriate forms of behavior.

III. PROCEDURES FOR ADVICE, REVIEW, AND CONSENT

The purposes of this section are to develop monitoring procedures that: (1) protect the rights and welfare of retarded clients; (2) maximize the quality and extent of services provided to clients; (3) allow conscientious and well-trained persons to administer appropriate treatment procedures with a sense of security, and (4) enable institutions to comply as economically and practically as possible, with both the form and the spirit of protective requirements set forth in recent legislation and court decisions.

These monitoring mechanisms are necessary and important because: (1) State programs for the retarded throughout the country provide services which have not in the past been closely scrutinized by the public, and this privacy allows for abuse of clients and residents and for services to be applied less faithfully than would be desirable for the maximum benefit to clients and residents. (2) Strong adverse public reaction to occasional abuses creates a climate in which employees are likely to assume that it is personally safer for them to do nothing than to carry out procedures which are important for the growth and development of clients and residents, but which might be susceptible to public criticism. (3) Procedures needed for public review and approval of new or possibly controversial behavioral procedures. (4) Ordinary mechanisms of professional control operating in the private sector may not be effective to prevent abuse in public institutions.

Committees for External Review of Procedures and Certain Treatment Decisions

1. Peer Review Committee

   a. One statewide Peer Review Committee (PRC) consisting of three or five members of demonstrated and recognized competence in behavioral programming should be established. Each member should be appointed by the Governor or his designate, superior to the Director of the Division of Retardation, based on recommendations from the state Association for Retarded Citizens. Names of candidates to be recommended should be solicited from such entities as universities, professional associations, and the editorial boards of behavioral journals. It is suggested that at least one member of this PRC should be authorized and encouraged to seek the assistance of professional consultants when it deems it necessary or appropriate in the carrying out of its functions. Prior to appointment, the

length of terms and rotation mechanisms along with the compensation and budget necessary for the Committee to do its job should be clearly established. At a minimum these should be rotation of the Committee by two-year staggered terms and compensation of at least $100 per day.

b. New behavioral procedures proposed for introduction to the treatment program of any facility under the jurisdiction of the Division should be first submitted to the PRC for its approval. Approval would be based on a professional judgment regarding the acceptability and efficacy of the procedures. The PRC may disapprove the proposed procedure, approve it, or approve it with certain specified modification, limitations, or restrictions.

c. The PRC shall also approve the necessity, acceptability and efficacy of procedures falling under paragraph 2(f) when proposed for use with regard to individual clients or residents or particular groups of clients or residents. The PRC will provide these and related services whenever requested by the Regional Director or his delegates.

2. Committees on Legal and Ethical Protection

a. There should be established a Committee on Legal and Ethical Protection (CLEP) for each region. Each CLEP should consist of 5 members unaffiliated with the state Division of Retardation and should include an experienced behavioral scientist, a lawyer (preferably with some experience in representing the handicapped or versed in matters of civil liberties), and such other members as would be appropriately interested in the rights of the retarded. There should also be represented on the CLEP a member of a retarded citizens' association who is also a parent or relative of a retarded person, a retarded individual himself, or both. The arrangement for appointing members of CLEP and the selection of members should be made outside of the state Division of Retardation, and length and rotation of terms, compensation, and budget should be clearly specified. At a minimum there should be rotation of the Committee by 2-year staggered terms, and compensation of at least $100 a day. Budgets for these committees should be appropriated by the state Division of Retardation. These committees should have access to outside consultants versed in behavioral procedures. If a sufficient number of nationally recognized behavioral experts are available in the vicinity, a regional Peer Review

Committee (PRC) might be formed to provide this consultation and review of each client's program. Where local experts are not available, the state PRC should provide this service, or provide the CLEP with lists of recognized experts who could provide them with independent evalutions of proposed treatment programs for individual clients or groups of clients.

b. The CLEP's should conduct periodic visitations to and inspections of facilities and programs within their respective regions to ensure continued familiarity with their operations and to ensure that the facilities and programs are properly seeking CLEP approval in required matters. They should assure that each client has an individualized treatment program. Appendix D is an excerpt from **Wyatt v. Stickney** in which the court spelled out the requirements for habilitation programs. CLEP's should sample cases and perform other functions as more fully described in Appendix E.

They shall also receive and investigate complaints regarding behavioral programs when lodged by clients, parents, staff, public officials, and members of the press or the public. In accordance with the standards specified below, the CLEP's shall also investigate and approve or disapprove behavioral programs or procedures proposed for introduction within the region or proposed for a particular client or group of clients. If a CLEP finds fault with any behavioral program, it should immediately notify both the regional PRC and the regional directors.

c. New behavioral procedures proposed for introduction in any facility or program shall, after approval by the state PRC, be submitted to the appropriate CLEP for its approval, which shall be based on its judgment regarding the appropriateness of the behavior proposed to be strengthened or weakened and on the ethical propriety of the means to be employed to achieve the behavior change.

d. It is recommended that a list of specific techniques be generally approved by the CLEP for strengthening and weakening a specified set of behavioral deficits and disruptive behaviors commonly encountered among retarded persons. All such techniques should then be performed in accordance with proper professional standards without case-by-case prior notification to or approval by the CLEP's. It is suggested that these techniques include

positive reinforcement, extinction, expressions of mild social disapproval (other than shouting or demeaning or abusive comments), contingent observation, and overcorrection (implemented by trained personnel), and the target behaviors to be strengthened by these techniques include self-help, mobility, and language, and those behaviors to weaken include self-mutilation and inappropriate self-stimulation.

e. Subject to approval by the state PRC and the appropriate CLEP, the following behavioral procedures (and others hereafter designated by the respective PRC's and CLEP's) shall be regarded as sometimes necessary and as relatively standard, reasonable, and conventional, and may be employed to modify the target behaviors in paragraph (d) above, when performed in accordance with proper professional standards without prior approval by CLEP's, so long as the CLEP's and the regional PRC are notified of the use of the procedures within seven days after their initial use. Thereafter, weekly reports of such use for a particular client or resident should be filed with the CLEP and PRC. It is intended that both the CLEP and PRC would monitor such reports for possible excessive, unnecessary, or ineffective use of the procedures covered in this paragraph. These procedures include exclusion timeout, fines, non-behavioral restraints, differential reinforcement of other behavior, and use of mini-meals.

f. The strengthening or weakening of behaviors not specified in paragraph 2(d) or the use of procedures not specified in paragraph 2(c) and 2(d) may be performed only after approval by the PRC when the appropriate CLEP finds, after gleaning and studying the relevant facts,

   i. that when a client has the legal capacity to consent* to the particular procedure he has given truly informed consent to the proposed procedure**, or when

   ii. the resident or client lacks the legal capacity to consent to the particular procedure and has been involved to the extent of his capacity in the decision-making process,

*To ensure that consent is truly voluntary, release criteria should be based on community readiness, skills, etc.; and should be independent of any specific program completion per se.

**Note that if the client is found to be competent and refuses to submit to the treatment, the paragraph 2(f) treatment could not be used. Nonetheless, if the client happens to be engaging in serious self-destructive or other aggressive behavior, he could be properly restrained.

but the parent or guardian of the resident or client has given informed consent and the CLEP is persuaded that the procedure has been approved by the PRC as meeting professional standards; that less restrictive alternatives have been exhausted without success or that they would be clearly ineffective; and that, on balance, the proposed treatment would be in the best interest of the client in terms of facilitating the normal developmental and educational goals. No proposed procedure shall be approved if it is highly intrusive, speculative, and appears to have a low chance of success and a substantial chance of producing damaging effects or side-effects. (This is not meant to suggest that all other methods should receive routine approval.)

iii. The client being asked to consent to the use of behavioral procedures or the setting of particular behavioral objectives should, at least, according to Wolf, Fixsen, and Phillips (1974) be provided with three things: (a) A description of the procedures or objectives and rationale including (1) Specific and detailed descriptions of the procedures and/or objectives. These might be presented both orally and in written form and, if they are particularly complex, demonstrated or modeled as they will occur. They should include estimates of the expected frequency and duration of use. (2) An explanation of why the procedures and/or objectives are thought to be important or potentially beneficial. This should include reviews of previous related use of the procedures and/or objectives. (3) A detailed description of any potential psychological or physical risks. (b) Information about other available options for procedures and/or objectives. (c) Information about procedures for withdrawing consent.

iv. If any member of the CLEP believes that the legal rights of any individual client are not adequately served by the CLEP review, legal counsel should be provided to advise competent clients who need to make the decision whether to undergo procedures, and/or counsel or advocate should be provided to present arguments against use of the proposed procedures for incompetent clients. In case of incompetent clients, the counsel or advocate should have the right and responsibility to appeal the

decision of the CLEP to a court of local jurisdiction if he feels that the decision is wrong on the merits or that procedures have been incorrectly followed.

(A detailed analysis of the legal concept of informed consent based on court decisions such as **Wyatt v. Stickney** is presented in Appendix F.)

g. If, in rendering a decision under paragraph f(ii) the CLEP finds that a less restrictive alternative is insufficient only because of the lack of staff or funds, it shall in each such case immediately notify all appropriate persons, such as the Director of the Division of Retardation, the Governor, the Secretary of the Department of Health and Rehabilitative Services, the Attorney General, the Chairman of the House and Senate HRS Legislative Committees, and the Chairman of the House and Senate Appropriations Committees. (Note that this paragraph takes no position regarding whether the CLEP should rule for or against a more restrictive procedure when it finds that less drastic measures are insufficient only because of inadequate resources.)

h. When carrying out their decision-making functions under paragraphs (f) and (g) the CLEP's shall render decisions in written form specifying the factual bases underlying their conclusions.

i. If any proposed procedures covered under paragraphs 2(c) or 2(f) are disallowed by any of CLEP, the PRC, the client or resident, or the parents or guardians and this decision leads to the necessity for nontreatment restraints because the client or resident is dangerous to himself or others, the program director will send a brief report of that state of affairs to each of the above parties and to the superintendent of the institutions and the regional director.

Contracting for Services

Private or public agencies, groups or individuals which contract to provide services should follow exactly the same advice, review, and consent procedures regarding behavioral objectives and behavioral procedures as are herein specified for the treatment programs operated by the Division of Retardation. To avoid contracting for services which might violate the spirit or letter of these advice, review, and consent procedures, it is recommended that whenever behavioral procedures or behavioral objectives

covered above under paragraphs 1(b), 1(c), 2(c), 2(d), 2(e), and 2(f) are to be employed by a contractor, the specified advice, review, and consent procedures be carried out prior to the letting of the contract. Moreover, the monitoring functions described above under paragraphs 2(b) and 2(c) should be carried out by CLEP's for all contracted programs.

BIBLIOGRAPHY

Azrin, N. H., and Holz, W. C. Punishment. In W. K. Hongi (Ed.), **Operant Behavior.** New York: Appleton-Century-Crofts, 1966, pp. 380-447.

Baer, D. M., and Sherman, J. A. The modification of child behavior: Application to therapy and education. In H. Reese and L. Lipsitt (Eds.), **Experimental Child Psychology.** New York: Academic Press, 1970, pp. 643-672.

Bandura, A. **Principles of Behavior Modification.** New York: Holt, Rinehart and Winston, Inc., 1969.

Barrish, H. H., Saunders, M., and Wolf, M. M. Good behavior game: Effects of individual contingencies for group consequences or disruptive behavior in a classroom. **Journal of Applied Behavior Analysis**, 1969, 2, 119-124.

Barton, E. S., Guess, D., Garcia, E., and Baer, D. M. Improvement of retardates' mealtime behaviors by time-out procedures using multiple baseline techniques. **Journal of Applied Behavior Analysis**, 1970, 3, 77-84.

Bijou, S. W., and Baer, D. M. **Child Development, Vol. I: A Systematic and Empirical Theory.** New York: Appleton-Century-Crofts, 1961.

Bostow, D. E., and Bailey, J. B. Modification of severe disruptive and aggressive behavior using brief time-out and reinforcement procedures. **Journal of Applied Behavior Analysis**, 1969, 2, 31-38.

Corte, H. E., Wolf, M. M., and Locke, B. J. A comparison of procedures for eliminating self-injurious behavior of retarded adolescents. **Journal of Applied Behavior Analysis**, 1971, 4, 201-213.

Ennis and Friedman (Eds.), **Legal Rights of the Mentally Handicapped** (3 Vols.), November 1973.

Forehand, R., and Baumeister, A. A. Deceleration of aberrant behavior among retarded individuals. In R. M. Eisler and P. M. Miller (Eds.), **Progress in Behavior Modification.** New York: Academic Press, in press.

Foxx, R. M., and Azrin, N. H. Restitution: A method of eliminating aggressive-disruptive behavior of retarded and brain-damaged patients. **Behavior Research and Therapy**, 1972, 10, 15-27.

Foxx, R. M., and Azrin, N. H. The elimination of autistic self-stimulatory behavior by overcorrection. **Journal of Applied Behavior Analysis**, 1973, 6, 1-14.

Friedman, P. R. "Mental Retardation and the Law: A Report on the Status of Current Cases," The Office of Mental Retardation Coordination, U. S. Department of Health, Education, and Welfare.

Friedman, P. R. Legal regulation of applied behavior analyses in mental institutions and prisons. **Arizona Law Review**, in press.

Friedman, P. R., **et al. Basic Rights of the Mentally Handicapped**, Mental Health Law Project, January 1973.

Jacobson, J. M., Bushell, D., and Risley, T. Switching requirements in a head start classroom. **Journal of Applied Behavior Analysis**, 1969, 2, 43-47.

Kaimowitz v. Department of Mental Health, 2 Prison L. Rptr. 443 (August 1973) 42 U.S.L.W. 2063 (July 31, 1973, Wayne County Circuit Court).

Kindred (Ed.). **The Mentally Retarded Citizen and the Law**, to be published by the President's Committee on Mental Retardation, Columbus, Ohio (May 3-5, 1973).

Knecht v. Gillman, 488 F.2d 1136 (8th Cir. 1973).

Konorski, J., and Miller, S. On two types of conditioned reflex. **Journal of General Psychology**, 1937, 16, 264-272.

Lovaas, O. I., and Simmons, J. Q. Manipulation of self-destruction in three retarded children. **Journal of Applied Behavior Analysis**, 1969, 2, 143-157.

Mackey v. Procunier, 477 F.2d 877 (9th Cir. 1973).

Macmillan, D. L., Forness, S. R., and Trumbull, B. M. The role of punishment in the classroom. **Exceptional Children**, 1973, 40, 85-96.

May, J. G., Jr. Ethical and legal contingencies in and upon behavior modification programs. Paper presented at Southeastern Psychological Association, New Orleans, 1973.

May, J. G., Jr. "Legal, moral and ethical considerations in behavior modification." In D. Gentry (Ed.) **Applied Behavior Modification.** St. Louis: C. V. Mosby, 1975.

Mills v. Board of Education, 348 F. Supp. 866 (D.D.C. 1972).

Note, "Conditioning and Other Technologies Used to 'Treat?' 'Rehabilitate?' 'Demonish?' Prisoners and Mental Patients," 45 S. Cal. L. Rev. 616, 1972.

O'Brien, F., Azrin, N. H., and Bugle, C. Training profoundly retarded children to stop crawling. **Journal of Applied Behavior Analysis**, 1972, 5, 131-137.

Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania, 334 F. Supp. 1257 (E. D. Pa. 1961).

Phillips, E. L., Phillips, E. A., Fixsen, D. L., and Wolf, M. M. Achievement place: Modification of the behaviors of pre-delinquent boys within a token economy. **Journal of Behavioral Analysis**, 1971, 4, 45-59.

Relf v. Weinberger and National Welfare Rights Organization v. Weinberger, C.A. No. 63-1557 U.S. District Court, D.C., 1974.

Risley, T. R. The effects and side-effects of punishing the autistic behaviors of a deviant child. **Jounal of Applied Behavior Analysis**, 1968, 1, 21-34.

Risley, T. R., and Baer, D. M. Operant behavior modification: The deliberate development of behavior. In B. M. Caldwell and H. N. Ricciuti (Eds.), **Review of Child Development Research, Vol. 3.** Chicago, Ill.: University of Chicago Press, 1973, pp. 283-329.

Sailor, W., Guess, D., Rutherford, G., and Baer, D. M. Control of tantrum behavior by operant techniques during experimental verbal training. **Journal of Applied Behavior Analysis**, 1968, 1, 237-243.

Shapiro, "Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies," 47 S. Cal. L. Rev. 237, Feb. 1974.

Souder v. Brennan, 362 F. Supp. 808 (D. C. Cir. 1973).

Webster, D. R., and Azrin, N. H. Required relaxation: A method of inhibiting agitative-disruptive behavior of retardates. **Behavior Research and Therapy**, 1973, 11, 67-78.

Weiner, H. Some effects of response cost upon human operant behavior. **Journal of the Experimental Analysis of Behavior**, 1962, 5, 201-208.

Welsh v. Likens, No. 4-72-Civ. 45., U.S. District Court, Minnesota.

Wexler, "Token and Taboo: Behavior Modification, Token Economies, and the Law," 61 Cal. L. Rev. 81, 1973.

Williams, C. D. The elimination of tantrum behavior by extinction procedures. **Journal of Abnormal and Social Psychology**, 1959, 59, 269.

Wolf, M. M., Birnbrauer, J. S., Williams, T., and Lawler, J. A note on apparent extinction of the vomiting behavior of a retarded child. In L. P. Ullmann and L. Krasner (Eds.), **Case Studies in Behavior Modification**. New York: Holt, Rinehart and Winston, 1965, pp. 364-365.

Wolf, M. M., Fixsen, D. L., and Phillips, E. L. Some suggestions for accountability procedures for behavior modification treatment programs. Paper presented at the meeting of the National Institute of Mental Health, June 1974.

Wolf, M. M., Risley, T. R., and Mees, M. Application of operant conditioning procedures to the behavior problems of an autistic child. **Behavior Research and Therapy**, 1964, 1, 305-312.

Woodworth, R. S., and Schlosberg, H. **Experimental Psychology**. New York: Holt, Rinehart and Winston, 1954.

Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971) 334 F. Supp. 1341 (M.D. Ala. 1971) 344 F. Supp. 373, 344 F. Supp. 387 (M.D. Ala. 1972) 368 F. Supp. 1383 (M.D. Ala. 1974) appeal docketed sub nom. **Wyatt v. Aderholt**, No. 73-2634, Fifth Circuit.

APPENDIX A

Procedures for Contingent Observation

Procedures for Contingent Observation

Basic Steps

For each situation, clients' caregivers specify the behavior which is appropriate and inappropriate. Clients can then learn what they can and cannot do.

Example: While working or playing at a table with other clients, it is appropriate to handle one's own materials, but inappropriate to grab someone else's.

Each time a client does something inappropriate, the caregiver immediately uses the opportunity to teach him the appropriate behavior. The caregiver tells the client what the appropriate behavior is, and why his behavior is inappropriate.

Example: "Johnny, you should be playing with your own blocks as the others are doing, not grabbing Sue's."

The caregiver asks the client to sit in a chair a short distance from the activity and watch what the others are doing. He now has the opportunity to see the appropriate behavior while not participating in the activity himself for a few moments.

Example: "Johnny, please sit in this chair for a few moments and watch how the others are using their own blocks."

The way the caregiver communicates to the clients and organizes the learning situation for them is tailored to their individual needs. A blind client may be led to the chair and instructed to think about how he should act. A caregiver may shake his head and frown to communicate to a deaf client that his behavior is inappropriate. Describing to the client the appropriate and inappropriate behavior for that situation not only instructs that particular client but extends the learning experience to the rest of the group, who are reminded of what they are expected to do.

The caregiver watches the client who is sitting in the chair to see when he looks as though he has learned something by watching the group, and is ready to rejoin the activity. The client is asked to indicate that he intends to behave appropriately.

Example: "Johnny, you've been watching nicely. Do you think you can play with your own blocks now without bothering the others?"

Depending upon the capabilities of the client, the caregiver asks him to nod his head or reply verbally. At first, the caregiver may have to model the words or help the client nod his head. The

client should pay attention and not resist these teaching efforts. If he does, the caregiver should interpret this as an indication that the client needs to learn more by sitting and watching the others for a while longer.

The client returns to the activity where he can demonstrate that he has learned from watching. The caregiver is particularly alert to this client so that his learning experience can be completed by feedback for appropriate behavior.

Example: "Johnny, I'm proud of you. You're playing very well with your own blocks now!"

Teaching Clients to Sit

Some clients cannot benefit from contingent observation because they do not know how to sit and watch the others. They immediately refuse to sit in the chair, or leave before indicating to the caregiver that they understand and intend to perform the appropriate behavior. The client may do this because of the distractions of the ongoing activity; he wants to rejoin the others, or the other clients provide an audience for showing off. Not only is the client deprived of a learning opportunity, but he disrupts the activity for the other clients. Another area, free of distractions, is necessary so that these clients can practice sitting before returning to sit in the chair and watch. In this area, the reasons for getting up (the activity, other clients) are not present. This area can be the client's room, a testing room or even the bathroom, provided that these are not being used for other purposes while the client is there. A chair is provided, but there should not be much else to do so that the client can practice sitting.

Each time a client refuses to sit in the chair, or leaves before he should, the caregiver immediately uses the opportunity to teach him to sit. The caregiver tells him what the appropriate behavior is, and why his behavior is inappropriate.

Example: "Johnny, you're supposed to sit in this chair and watch the others. Since you are showing off and won't sit here, you will have to come to another area where the other clients won't distract you."

The caregiver takes the client to another area and explains that he must practice sitting for a few moments before returning to the chair. The door is left open. Of course, the door can be closed or latched to further reduce distractions if necessary, if a caregiver is nearby to monitor him.

Example: "Please sit here for a few moments. When you show me that you can sit, we'll go back to the chair so you can watch the others."

When the client appears to be able to sit in another area and looks ready to try sitting in the chair, he is asked to indicate that he can now sit in the chair.

Example: "Johnny, I see you're sitting nicely in this area. Do you think you can try to sit in the chair now and watch the others?"

Depending upon his capabilities, the caregiver asks him to nod his head or reply verbally. The caregiver takes the client back to the chair so that he has the opportunity to watch the others behave appropriately. Then, the client is asked to indicate that he understands what he is supposed to do, returns to the activity, and receives feedback for appropriate behavior.

Giving Clients an Opportunity to Calm Down

Some clients cannot benefit from contingent observation because they become very upset, disruptive, or aggressive when asked to sit in the chair. They cry, make loud noises, and generally disrupt the activity for the others. These clients are deprived of a learning opportunity since their behavior interferes with watching the appropriate behavior of the others. Another area is necessary so that these clients can calm down before returning to sit in the chair and watch. The steps taken by the caregivers to allow the client to calm down are generally the same as those for teaching him to sit.

Each time a client becomes upset, disruptive or aggressive when asked to sit in the chair and watch, the caregiver immediately gives him the opportunity to calm down so that he can benefit from contingent observation. The caregiver tells him what the appropriate behavior is, and that he has to calm down before he can do it.

Example: "Johnny, you're supposed to sit in this chair quietly and watch the others. But you're too upset to do that right now. Come to this area where you can calm down."

The caregiver takes the client to another area and explains that he will have to be calm and quiet before he can sit in the chair. The door is left open. Of course, the door can be closed or latched to help the client calm down, if necessary, if a caregiver is nearby to monitor him.

Example: "When I hear that you're being calm and quiet we'll go back to the chair so you can watch the others."

When the client appears calm and ready to try and watch the others, he is asked to indicate that he is ready.

Example: "Johnny, I see you're calm and quiet. Do you think you can sit in the chair and watch the others?"

The caregiver now continues with the contingent observation procedure since the client is now more likely to benefit.

Additional Information About Contingent Observation

Contingent observation and the procedures for teaching clients to sit or allowing them to calm down will, at first, have to be implemented frequently. As the clients learn to sit in the chair and not respond to the learning situation by becoming upset, another area will not need to be used very often. As the clients sit and watch the others they will learn to behave appropriately so that contingent observation will not be needed as frequently.

The contingent observation procedures do not specify the length of time a client should sit and watch the others, or the amount of time he should practice sitting or being calm in another area. These can be tailored to fit the needs of the individual client. Some may quickly learn what is expected of them and require less than a minute, while others may require fifteen minutes. Usually, from one to five minutes will suffice, and rarely more than fifteen.

The success of the contingent observation experience will depend upon the consistency with which the caregivers use it to teach appropriate behavior. Allowing a client to refuse to participate is not beneficial to him since it deprives him of the opportunity to obtain the information he needs to behave appropriately.

When a client needs to go to another area to practice sitting or to calm down, a record should be kept of the amount of time he needed to be there.

If a client is very upset when asked to go to another area to calm down, it may be necessary to remove objects which can be easily destroyed, or with which the client can hurt himself.

Contingent observation alone will probably not be successful in teaching a client a skill he does not have. For example, if he has never been toilet-trained, simply watching other clients use the toilet will probably not teach him to use it. However, contingent observation can be used in conjunction with other programs to teach these skills.

It must be emphasized that what the caregivers say to the clients while using contingent observation is an extremely important component of the procedure for several reasons. It communicates to the client what is expected of him, and reiterates the rules to the other clients. Furthermore, the verbal behavior of the caregivers about what they are doing provides a clear rationale for both staff and any observers about the purpose of contingent observation. For these reasons it is essential that caregivers explain to a client what is happening even if the client is non-verbal and would not be likely to understand.

APPENDIX B

Procedures for Educational Fines

TEACHING-PARENTS AS TEACHERS*

A critical feature of a Teaching-Family program is the teaching interaction that occurs when a teaching-parent is attempting to teach a new skill to a youth. These teaching interactions are supplemented by counseling, fun activities, and other pleasant interactions that are important to developing personal relationships with the youths. The effectiveness of a Teaching-Family group home greatly depends upon these teaching and personal interaction skills of the teaching-parents. Without these skills the group home can be little more than a custodial facility. However, by using these skills the teaching-parents can create a pleasant environment that is conducive to improving the youths' behavior.

The point system (see Chapter IV) is an important part of the teaching process because earning points strengthens appropriate behavior and point fines reduce inappropriate behavior. In this manner the point system provides the motivation for the youths to change their behavior. Most of the youths who enter the program need to learn new skills. For example, most of the youths need to learn new interpersonal skills so that they are able to improve their relationships with their parents, teachers, and other significant adults. The point system alone will not do a very good job of teaching these new behaviors. An instructional technique that we refer to as the teaching interaction is necessary to teach new behaviors. We have found that when the point system is used without the teaching interaction behavior the program often becomes suppressive. The points and fines come to be used only to suppress inappropriate behavior rather than as a motivation system to teach new skills that can be used to solve interpersonal problems and to obtain goals. A suppressive point system can be avoided by using the teaching interaction to teach these new skills.

The Teaching Interaction

The teaching interaction consists of 10 components. These components involve the expression of affection, praise for work already accomplished, descriptions of inappropriate and of appropriate behavior, the rationale for the appropriate behavior, request for acknowledgement that the youth understands, practice, feedback and finally rewards such as praise and points for a job well done.

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*Chapter in: The Teaching-Family Handbook, Phillips, E. L., Phillips, E. A., Fixsen, D. L., and Wolf, M. M., University of Kansas, 1972.

An example of a teaching interaction is presented below*. It began with the teaching-parent assigning a youth the duty of cleaning the kitchen sink and counter top for the first time. The teaching interaction that follows occurred when the teaching-parent returned to see how the youth was doing.

Teaching Interaction Component	Example	Reason the component may be important
1. Expression of affection (a smile, special greeting, joke, physical contact)	Teaching-parent smiles and says, "Hi. Are you having any problems?" He places his hand on the youth's shoulder.	Indicates to the youth that the teaching-parent is pleased to see him, likes to interact with him and is concerned about any problems he may be having.
2. Praise for what has been accomplished.	"Say, that sink looks fine."	Indicates to the youth that teaching-parent is aware of what he has already accomplished.
3. Description of the inappropriate behavior.	"But you haven't gotten this counter top clean."	Instructs the youth about what he did incorrectly or hasn't yet done.
4. Description of the appropriate behavior. (A demonstration may be necessary.)	"So why don't you get a damp, soapy rag and wipe off the counter. Be sure that you rub hard on these spots of stuck-on food. [Teaching-parent points to them.] Let me show you what I mean. [Teaching-parent demonstrates.]"	Instructs the youth about what is expected of him. The task often should be broken into small steps. Demonstration may be needed in order to clarify the verbal instruction.
5. Rationale for the appropriate behavior.	"We want you to know how to take care of a kitchen so that when you have your own apartment it will look nice. And you'll be able to help around your house if your parents ask you to. Also, we need to keep the kitchen clean so we can keep the germs away. Also, if we have visitors they won't get a bad impression of us."	Instructs the youth why it is important that he engage in the behaviors, i.e., the potential future consequences.

Teaching Interaction Component	Example	Reason the component may be important
6. Description of the present consequences.	"As soon as you finish cleaning the counter top you can have your points."	Instructs the youth about the immediate rewards for his appropriate behavior.
7. Request for acknowledgement.	"Do you understand?" or "Ok?"	Prompts the youth to ask any questions he may have. Also, the youth's acknowledgement provides feedback to the teaching-parent that the youth was attending to the instructions and understands them. (It is quite aversive for the teaching-parent if the youth is completely unresponsive throughout the teaching interaction.)
8. Practice	"Now, why don't you try to clean these spots?"	Practice is a very important component because it gives the teaching-parent immediate feedback whether the appropriate behavior is in the youth's repertoire and he understands the instruction.
9. Feedback during practice: Praise and correction.	"That looks good. How about rubbing this spot a little harder. That's right."	Provides positive feedback for those behaviors the youth is performing correctly and provides further instruction and practice for the behaviors that are not yet appropriate.
10. Reward: Praise and points.	"Give yourself 1,000 points. That is a fine job."	Gives the youth immediate consequences for the appropriate behavior.

Of course, all ten components will not be needed in every teaching interaction. For example, if a youth has had a lot of experience cleaning the counter top appropriately then there would be no need for a description of the appropriate behavior, rationale, description of the consequences (points), practice, or

*A mnemonic device for helping the student remember this list of ten components of a teaching interaction is, "A PARENT IN A RUSH CAN ALWAYS PRAISE FOR REWARD." The letters, A, P, I, A, R, C, A, P, F, R, are also the first letters of the important words describing each of the ten components:

A= Affection
P = Praise
I = Inappropriate
A= Appropriate
R= Rationale
C= Consequences
A= Acknowledgement
P = Practice
F = Feedback
R= Reward

feedback during practice. In addition, if the youth and the teaching-parent had been interacting rather closely together and some signs of affection had already been expressed (i.e., joking together) then there would be no need for the affection component. Finally, the youth may be on the merit system and so no points would be included in the reward. The teaching interaction might only involve the components of praise for accomplishment, description of inappropriate behavior, request for acknowledgement, and reward in the form of praise. This teaching interaction sequence might be as follows:

1. Praise for what has been accomplished.	"Say, that sink looks fine."
2. Description of inappropriate behavior.	"But, why don't you try to clean this counter top right here."
3. Request for acknowledgement.	"Ok?"
4. Reward: Praise only.	"Hey, that is a fine job."

When the teaching components occur they will be individualized by the style of each of the teaching-parents. For example, the style of expressing affection will vary with each teaching-parent. Some teaching-parents have easy smiles and others have pleasant facial expressions and voice qualities that they use to express affection. Others have a manner of joking and playfulness that they use to begin most interactions in a friendly and affectionate way. Some teaching-parents have a very pleasant style of physical contact that involves putting their arm around the youths' shoulders and hugging them a little. Whatever the manner of expression of affection the purpose is the same; the teaching-parent wants to communicate to the youth that he likes the youth and enjoys interacting with him even when he is correcting an inappropriate behavior and teaching a new skill.

We probably should consider some poor examples of teaching interactions. Every teaching-parent will probably, on rare occasions, engage in a poor teaching interaction. What is important is that the teaching-parents be able to recognize a poor interaction and be able to correct their behavior in the future.

For example, a poor interaction that can frequently occur involves the teaching-parent only using descriptions of inappropriate behavior when attempting to correct behavior.

Teaching Interaction Component	Example
1. Description of the inappropriate behavior.	"You haven't gotten this counter top clean."

Such an interaction, void of any affection, praise for work accomplished, etc., is aversive to the youth and to anyone else who may be observing, such as another youth or a visitor. Adding as many teaching components as are appropriate to this interaction would turn the interaction into a pleasant, instructive and perhaps even fun event.

Teaching-parents also occasionally engage in other poor teaching interactions involving such undesirable components as cursing, name calling, shouts, threats, and demands. Research has indicated that youths in Teaching-Family homes prefer interactions without these impolite components. Consider the interaction below:

Teaching Interaction Component	Example
1. Description of the inappropriate behavior with cursing, name calling, shouting, threatening and demanding components.	"Damn you dummy. You haven't gotten this counter top clean. You clean it off right now or you are going to get it." (All said in a shouting manner by the teaching-parent.)

There will be occasions when the teaching interaction will require a component of seriousness. For example, there will be instances when youths will have engaged in seriously inappropriate behavior that involves violation of the law, suspension from school or a flight in the community. It will then be necessary for the teaching-parent to become very serious. In addition there may be almost no positive components in the interaction. There are occasions when such interactions are appropriate and necessary.

Teaching Interaction Component	Example
1. Description of the seriousness of the situation.	"I have something very serious to discuss with you." (Serious tone of voice and facial expression.)
2. Description of the inappropriate behavior.	"I got a call from your teacher and I understand that you called her an obscene name."

Teaching Interaction Component	Example
3. Description of appropriate behavior.	"We have to make sure that you learn to avoid calling teachers names in the future."
4. Rationale	"You know that if you get in this kind of trouble again they plan to permanently expel you."
5. Description of present consequences.	"This obscene name is going to cost you a lot of points and probably means you won't be able to buy many privileges next week unless you really work hard to make up the points you are losing."
6. Practice.	"One way you can earn back some of the points that you have lost is to practice how you are going to apologize to the teacher and also how you are going to speak to her the next time that you think she is being unfair and you are mad at her."
7. (Feedback during practice and reward would then take place.)	

It can be seen from the above examples that the interaction pattern of the teaching-parents is a very important aspect of the program. A strong point system will provide the youth with the motivation. But, skillful teaching-parents who can incorporate the appropriate teaching components into their teaching interactions are essential for the success of the program.

The Principle of Positive Correction

The principle of positive correction: when points or privileges are lost for some misbehavior, the regaining of those points or privileges can be made dependent upon the youth engaging in the appropriate behavior or some approximation to the appropriate behavior. For example, points may be lost by a youth not taking fines appropriately. If the principle of positive correction were followed then most of the points that were lost would be earned back by practicing the appropriate reaction to fines and to criticism which would increase the likelihood that the youth would display the appropriate behavior when a fine was next given.

Another example might involve the fights or disagreements that occasionally occur between the youths that can cause a loss of points. According to the principle of positive correction the youths would earn the points back by engaging in appropriate behaviors that were missing when the fight occurred. This could involve behaviors such as hanging around within a few feet of one another for an extended length of time (an hour), cooperating with one another and making sincere complimentary statements to one another.

A final example could involve a youth suspended from school for talking back to the principal. Most of the points lost could be earned back by first practicing an appropriate response to the principal while at home and then by actually engaging in the appropriate behavior in front of the principal in the principal's office with the teaching-parent the next day at school.

The principle of positive correction means that the discipline would always fit the inappropriate behavior. The inappropriate behavior would have been engaged in because a particular skill that could have avoided the incident was weak or non-existent. Through positive correction the specific problems that were causing the loss of points or privileges would become opportunities for teaching the appropriate behaviors that could have avoided the problems in the first place. In a program that is based on positive correction, fines become not just punishment but opportunities for teaching and learning.

APPENDIX C

Procedures for Overcorrection

69

Procedures for Overcorrection[1]

A specific restitution and positive practice routine is designed for each type of appropriate behavior the clients need to learn. This routine is not arbitrary, but relevant to the physical and psychological damage caused by the disruption. The environment must be restored to better than its original condition, and the client is given the opportunity to practice the specific appropriate behavior for that situation. Examples of several types of overcorrection procedure are:

Household orderliness training: If the client has disturbed the appearance of the environment, he needs to learn to properly care for property. He not only corrects the particular disturbance he created; i.e., picking up the chair he threw, but straightens the rest of the objects in the room.

Social reassurance (apology) training: If the client has caused fear and apprehension among the other clients, he needs to learn to be considerate of the feelings of others. He apologizes by word or gesture; i.e., stroking on back, to all persons present, assuring them that he will not frighten them again.

Oral hygiene training: If the client has exposed himself to possible infection by biting others or mouthing objects, he needs to learn to be aware of the things in his environment that should not contact his mouth. He cleans his mouth with an oral antiseptic to prevent possible infection.

Medical assistance training: If the client has physically injured another person, he needs to learn to restore that person's comfort as much as possible by assisting in providing medical treatment, and helping to fill out the medical report.

Quiet training: If the client has created a noisy disturbance by screaming or shrieking, he needs to learn to be exceptionally quiet. He goes to a bedroom area to lie quietly on a bed.

These examples of overcorrection procedure can be used either singly or in combination depending upon the appropriate behavior the client needs to learn. For example, if a client screams, throws a chair and frightens other clients in a single episode, then he needs to learn to be quiet, to treat property with care, and to be considerate of the feelings of others. An overcorrection learning experience should last approximately 30 minutes.

Each time the client behaves inappropriately, the caregiver immediately uses the opportunity to teach him the appropriate

behavior through the overcorrection routine specific to that behavior. The routine is never arbitrary. For example, a client would never be required to rinse his mouth with an oral antiseptic if he had thrown an object, since he needs to learn the proper way to treat property.

The caregiver instructs the client to perform the overcorrection routine; i.e., "First, pick up that chair and put it back in the corner. Now pick up the magazine and put it on the table." Since the client must learn that this is a time of serious education rather than firendly social interaction, the caregiver does not compliment the client, but simply continues the instructions.

The way the caregiver instructs the clients is tailored to their individual needs. Some clients may not respond to the instructions and need to be manually guided to learn the appropriate behavior. The caregiver uses only as much physical pressure as necessary to teach the client the movement, reducing this as soon as the client begins to perform the movement himself. If the movement slows down or stops, just enough manual guidance is given to get it started again. The client is given the opportunity to learn the appropriate behavior, and can then practice it himself.

The way in which the clients participate in the overcorrection routine is also tailored to their individual capabilities. For example, nonverbal clients are taught to apologize by nodding their heads in response to questions from the caregiver concerning their intentions not to hurt others or cause a disturbance again.

The client must actively and continuously participate in the overcorrection procedure, without pausing, for the 30-minute period to ensure that he has the maximum opportunity to learn the appropriate behavior. The hard work involved in restoring the environment after a disruption may also remind him to engage in the appropriate behavior in the future.

At first, before a client has learned to cooperate with the caregiver in performing the overcorrection routine, he may attempt to end the learning situation by attacking the caregiver. When this occurs, the entire procedure should begin again for another 30 minutes so that the client learns that he must make amends and learn the appropriate behavior.

Positive Practice for Self-Stimulation

The overcorrection rationale has been applied to the design of a positive practice routine to teach self-stimulating clients appropriate limb posture and movement. A specific positive practice

routine, called functional movement training, is designed for the body part the client needs to learn to use appropriately. A client who repetitively claps his hands for no apparent reason would practice hand posture and movements, while a client who weaves his head continually would practice head posture and movement.

Each time the client is self-stimulating, the caregiver immediately uses the opportunity to teach him the appropriate behavior.

The caregiver instructs the client to perform the positive practice routine, which consists of a series of instructions about body movement and keeping still. For example, a client who claps his hands repetitively would be asked to put his hands in his pockets and keep them there for 15 seconds, when another movement instruction is given. Instructions are given for a period of five minutes each time the client is self-stimulatory.

The way the caregiver instructs the clients is tailored to their individual needs. Some clients may not respond to the instructions, and need to be manually guided at first, to learn the appropriate behavior.

Although a period of five minutes of practice is generally recommended, the length of time may have to be adjusted to fit the needs of the individual client. If he does not appear to be learning the appropriate posture and movement, then the length of practice should be increased.

It must be emphasized that caregivers need to be able to describe what they are doing and the purpose of the overcorrection procedures. This will allow them to give a clear rationale for them to other clients and to anyone else who observes the routine.

Footnote

[1]The following procedures have been summarized from the extensive investigations of overcorrection by N. H. Azrin and his colleagues which are reported in the following articles:

Foxx, R. M. and Azrin, N. H. Restitution: a method of eliminating aggresive-disruptive behavior of retarded and brain damaged patients. **Behavior Research Therapy**, 1972, 10, 15-27.

Foxx, R. M. and Azrin, N. H. The elimination of autistic self-stimulatory behavior by overcorrection. **Journal of Applied Behavior Analysis**, 1973, 6, 1-14.

Webster, D. R. and Azrin, N. H. Required relaxation: a method of inhibiting agitative-disruptive behavior of retardates. **Behavior Research and Therapy**, 1973, 11, 67-78.

APPENDIX D

Section Pertaining to Individualized Habilitation Plans from Wyatt v. Stickney

Section Pertaining to Individualized Habilitation Plans from Wyatt v. Stickney*

Individualized Habilitation Plan

1. Prior to his admission to the institution, each resident shall have a comprehensive social, psychological, educational, and medical diagnosis and evaluation by appropriate specialists to determine if admission is appropriate.
   a. Unless such preadmission evaluation has been conducted within three months prior to the admission, each resident shall have a new evaluation at the institution to determine if admission is appropriate.
   b. When undertaken at the institution, preadmission diagnosis and evaluation shall be completed within five days.
2. Within 14 days of his admission to the institution, each resident shall have an evaluation by appropriate specialists for programming purposes.
3. Each resident shall have an individualized habilitation plan formulated by the institution. This plan shall be developed by appropriate Qualified Mental Retardation Professionals and implemented as soon as possible but no later than 14 days after the resident's admission to the institution. An interim program of habilitation, based on the preadmission evaluation conducted pursuant to Standard 7, supra, shall commence promptly upon the resident's admission. Each individualized habilitation plan shall contain:
   a. a statement of the nature of the specific limitations and specific needs of the resident;
   b. a description of intermediate and long-range habilitation goals with a projected timetable for their attainment;
   c. a statement of, and an explanation for, the plan of habilitation for achieving these intermediate and long-range goals;
   d. a statement of the least restrictive setting for habilitation necessary to achieve the habilitation goals of the resident;
   e. a specification of the professionals and other staff members who are responsible for the particular resident's attaining these habilitation goals;

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*The material presented here corresponds to III (7-14) in Wyatt v. Stickney.

f. criteria for release to less restrictive settings for habilitation, including criteria for discharge and a projected date for discharge.

4. As part of his habilitation plan, each resident shall have an individualized post-institutionalization plan. This plan shall be developed by a Qualified Mental Retardation Professional who shall begin preparation of such plan prior to the resident's admission to the institution and shall complete such plan as soon as practicable. The guardian or next of kin of the resident and the resident, if able to give informed consent, shall be consulted in the development of such plan and shall be informed of the content of such plan.

5. In the interests of continuity of care, one Qualified Mental Retardation Professional shall be responsible for supervising the implementation of the habilitation plan, integrating the various aspects of the habilitation program, and recording the resident's progress as measured by objective indicators. This Qualified Mental Retardation Professional shall also be responsible for ensuring that the resident is released when appropriate to a less restrictive habilitation setting.

6. The habilitation plan shall be continuously reviewed by the Qualified Mental Retardation Professional responsible for supervising the implementation of the plan and shall be modified if necessary. In addition, six months after admission and at least annually thereafter, each resident shall receive a comprehensive psychological, social, educational and medical diagnosis and evaluation, and his habilitation plan shall be reviewed by an inter-disciplinary team of no less than two Qualified Mental Retardation Professionals and such resident care workers as are directly involved in his habilitation and care.

7. In addition to habilitation for mental disorders, people confined at mental health institutions also are entitled to and shall receive appropriate treatment for physical illnesses such as tuberculosis. In providing medical care, the State Board of Mental Health shall take advantage of whatever community-based facilities are appropriate and available and shall coordinate the resident's habilitation for mental retardation with his medical treatment.

8. Complete records for each resident shall be maintained and shall be readily available to Qualified Mental Retardation Professionals and to the resident care workers who are directly involved with the particular resident. All information contained

in a resident's records shall be considered privileged and confidential. The guardian, next of kin, and any person properly authorized in writing by the resident, if such resident is capable of giving informed consent, or by his guardian or next of kin, shall be permitted access to the resident's records. These records shall include:

a. identification data, including the resident's legal status;

b. the resident's history, including but not limited to:
   (1) family data, educational background, and employment record;
   (2) prior medical history, both physical and mental, including prior institutionalization;

c. the resident's grievances if any;

d. an inventory of the resident's life skills;

e. a record of each physical examination which describes the results of the examination;

f. a copy of the individual habilitation plan and any modifications thereto and an appropriate summary which will guide and assist the resident care workers in implementing the resident's program;

g. the findings made in periodic reviews of the habilitation plan (see Standard 12, supra), which findings shall include an analysis of the successes and failures of the habilitation program and shall direct whatever modifications are necessary.

APPENDIX E

Recommended Program Monitoring Procedures for Use by the Committees on Legal and Ethical Protection

77

Recommended Program Monitoring Procedures for Use by the Committes on Legal and Ethical Protection

Functions

The basic concept is that systematic monitoring of the behavioral programs can be achieved through a sampling concept. This should be carried out in three ways. The Committee should sample and thoroughly review: (a) current cases; (b) staff; (c) the degree to which advances in the area of applied behavioral science are being implemented.

Case Sampling

A small, random sample of current cases should be drawn by the Committee (8-10). They should ask:

1. Whether a client or resident is fully programmed.
2. Whether behavioral techniques are being used.
3. If so: (a) whether target behaviors are clearly specified, whether procedures are clearly specified or capable of being known, through references to well-documented programs or to journal articles; (b) how their goals and means have been classified by the appropriate CLEP and whether there is documentation of all the procedures required thereby; (c) whether the appropriate monitoring is being kept current; (d) whether the methods approved by CLEP, in individual or "c" type procedures are the procedures, in fact, being employed.
4. Whether appropriate consent was obtained.

Operations

The CLEP might meet at least bi-monthly, for one day. They should be paid by the state Division of Retardation at the current consulting rate at the time, not less than $100 per day. Secretarial help, supplies, and such other staff assistance as is needed should be provided by office of the Regional Coordinator of Behavioral Programming.

Members should be appointed to two-year staggered terms.

APPENDIX F

Information Relevant to Informed Consent

Information Relevant to Informed Consent*

1. Informed consent requires consent that is: (a) based upon an understanding of the nature and consequences of the procedure; (b) wholly voluntary and free from any coercion, overt or covert; and (c) given by a person competent to make such a decision.
2. For purposes of this regulation, the knowledge component "informed consent" requires that the therapist directly communicate with the client/resident and clearly and explicitly provide all the following information:
   a. The nature and seriousness of the client's behavioral problem and the proposed specific objectives for the client;
   b. The nature of the proposed procedure to accomplish these objectives, its probable duration and intensity;
   c. The likelihood of improvement or deterioration, temporary or permanent, without the administration of the proposed procedure;
   d. The likelihood and degree of improvement, remission, control, or cure resulting from the administration of such procedure; the likelihood, nature, and extent of changes in and intrusions upon the person's personality and patterns of behavior and thought resulting from such therapy; and, the degree to which these changes may be irreversible;
   e. The likelihood, nature, extent, and duration side effects of the proposed procedure, and how and to what extent they may be controlled, if at all;
   f. The uncertainty of the benefits and hazards of the proposed procedure;
   g. The reasonable alternative therapies or procedures available and an explanation why the specific procedure recommended has been chosen. These alternatives shall be described and explained to the client resident in the same manner as the recommended therapy;
   h. Whether the proposed procedure is generally regarded as established therapy by applied behavior analysis or is considered experimental.

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*For further discussion of these issues, see Friedman, P. F., Legal regulation of applied behavior analysis in mental institutions and prisons. **Arizona Law Review**, Summer, 1975, p. 40-143, from which this excerpt was taken.

i. A description of the procedure for termination of the treatment program prior to completion and clear notification whether consent or waiver may be withdrawn at any time;

j. The data-gathering procedures which will be used to evaluate the program.

3. There shall be no coercion in any form with regard to the decision to accept these procedures. The client/resident must be informed orally and in writing that no benefits or penalties will be made contingent upon participation in the proposed program or agreement to undergo the proposed procedure. Specifically, there must be an explicit understanding by the client/resident that his consent is not a precondition for release from the institution, and his decision should not be made to obtain approval from or avoid reprisals from the staff. Any individual having knowledge of implicit or explicit coercion of a client/resident shall immediately bring such information to the attention of the facility's HRC. Failure to do so shall be punishable as provided by law.

4. A person confined shall be deemed incapable of giving informed consent if such person cannot understand and knowingly act upon the information specified under section (1) above, or if for any other reason he cannot manifest his consent to the attending therapist. A client confined to a mental institution shall not be considered incompetent solely because of his institutionalization.

   To aid the CLEP in assessing the client's competency, the director of the facility or his designated representative shall prepare a written report evaluating the resident's understanding of the proposed procedure and describing the steps taken to inform the resident of the nature and consequences of the procedure.

5. If the client/resident has been determined to be legally incompetent by a court of competent jurisdiction, or if the director or his designated representative cannot certify without reservation that the client/resident understands the nature and consequences of the proposed procedure, the procedure may not be used unless the parents, in the case of a minor, or the guardian, in the case of an adult incompetent, of the client/resident have given informed consent and the CLEP is persuaded that: the procedure complies with generally accepted professional standards; less intrusive alternatives either have been exhausted without success or

would be clearly ineffective; the benefits of the procedure clearly outweigh the harms; and the procedure would be in the best interest of the client/resident. If in rendering a decision under this paragraph the CLEP finds that a less restrictive alternative is insufficient only because of the lack of staff or funds, it shall immediately notify the director, the governor, the attorney general, and the chairmen of the appropriate legislative committees, including Health and Appropriations.

82

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1975-76

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